MEDICARE COVERAGE AND REIMBURSEMENT OF SKILLED NURSING FACILITY SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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MEDICARE COVERAGE AND REIMBURSEMENT OF SKILLED NURSING FACILITY SERVICES

TUESDAY, FEBRUARY 2, 1982

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, at 10 a.m., pursuant to notice, in room H-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[Press release announcing the hearing follows:]

[Press release of Wednesday, January 20, 1982]

HON. ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCES HEARING ON MEDICARE SKILLED NURSING FACILITY COVERAGE AND REIMBURSEMENT

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, announced today that the Subcommittee will hold a public hearing on medicare coverage and reimbursement of skilled nursing facility services on Tuesday, February 2, 1982, beginning at 10 a.m., in Room B-318 Rayburn House Office Building. The hearing will examine the possible elimination of the 3-day prior hospital stay requirement for medicare skilled nursing facility coverage, and possible changes in medicare reimbursement policies and administrative procedures relating to skilled nursing facilities.

BACKGROUND

The medicare program provides coverage of up to 100 days of "post-hospital extended care services" in a qualified skilled nursing facility following a hospital stay by the beneficiary that lasted at least 3 days. This coverage was provided to encourage convalescence in a skilled nursing facility following hospital treatment, where this is medically appropriate, as an alternative to the continued occupancy of a high-cost acute care hospital bed. Questions have been raised about the continued desirability and necessity of the 3-day prior hospital stay requirement, and legislation (H.R. 4227) has been proposed to eliminate the requirement.

Access to skilled nursing facility services is a serious problem for many medicare beneficiaries. In recent years, there has been concern about the significant numbers of medicare beneficiaries who inappropriately remain in high-cost hospital beds because no skilled nursing facility bed is available in the area.

In section 919 of Public Law 96-499, the Congress directed the Department of Health and Human Services to study and report on the availability of skilled nursing facility services under medicare and medicaid, the possible usefulness of a requirement for dual participation by skilled nursing facilities in both medicare and medicaid, and possible changes in regulations and legislation which would encourage greater availability of skilled nursing facility services.

It has been argued that a revision of medicare reimbursement policies and procedures for skilled nursing facilities, including adoption of some form of prospective reimbursement, would induce more skilled nursing facilities to accept larger numbers of medicare patients, as would a reduction in paperwork now required of skilled nursing facilities.

The Subcommittee seeks testimony on all these matters, and especially on the following:

1. The advantages and disadvantages of eliminating the 3-day prior hospital stay requirement, including anticipated effects on medicare program costs and on continued enforcement of the requirement that the patient need and actually receive skilled nursing or skilled rehabilitation services on a daily basis.
2. Possible changes in medicare reimbursement policies and procedures for skilled nursing facilities, including a prospective reimbursement system.
3. Other possible changes in regulations, administrative procedures, or law that would encourage additional medicare participation by skilled nursing facilities.

The Subcommittee notes that it does not seek testimony at this time on possible changes in skilled nursing facility conditions of participation that are reported to have been under consideration by a Department of Health and Human Services task force on deregulation. The Subcommittee may wish to examine this issue in the future if circumstances warrant.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony at the hearing should submit their requests to be heard by telephone to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515; telephone: (202) 225-3627. The initial telephone request must be received by the Committee no later than noon, Wednesday, January 27, 1982. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

Requests to be heard must contain the following information:

(1) The name, address, title, firm affiliation and/or organization the witness will represent (as well as a telephone number where he or his designated representative may be reached);

(2) If appearing in an individual capacity, a list of any clients at whose request or in whose employ the witness appears; and

(3) A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statements to be presented in person as well as those filed for the written record of the hearing.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 50 copies of their prepared statement to the full Committee office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearings, five copies are required and may be submitted to the Committee office by the close of business Friday, February 12, 1982. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman JACOBS. We are conducting hearings today on the question of the 3-day hospital stay requirement in order to enter a skilled nursing home facility under the medicare program. Some argue that it unreasonably limits access to skilled nursing homes, and also that it leads to sham visits to hospitals just in order to get into nursing homes.

Others argue that the purpose of the requirement is to make certain that someone is sick enough that he needs to go to the hospital, and then rather than recovering in a hospital, can recover in a less expensive facility.

Our first witness today, representing the Health Care Financing Administration of the Department of Health and Human Services, is Patricia Hirsch Feinstein, not mayor of any city that I know of but Associate Administrator for Policy.

I yield to my colleague, Mr. Gradison from Ohio.

Mr. GRADISON. Thank you, Mr. Chairman. I would like to say this hearing is most timely and that I welcome this opportunity to hear our witnesses on several issues affecting the medicare program. The major issues we will be talking about and discussing today, such as the 3-day prior hospitalization requirement, prospective versus retrospective payments to skilled nursing facilities, mandatory participation in medicare and medicaid, are very important, but they also illustrate the need for us to think in even broader terms about two massive problems facing our health care delivery system: First, the need to restructure our reimbursement policies to provide incentives that will enable consumers to obtain the most cost-effective care available, whether acute or long-term care; and second, the critical need to find means for our rapidly expanding elderly population to obtain access to and finance long-term care, especially health care, in a year where Government resources clearly will not be available without limit.

I am confident that the testimony received today will enable us to better focus on the need of our elderly and disabled citizens for cost-effective, long-term care, both institutional and noninstitutional, and to find innovative solutions to the complex, difficult task of reducing the rate of increase in the huge cost of medicare in a way that will benefit, not harm, the beneficiaries of this important program.

In sum, Mr. Chairman, I think we are at a point in the medicare program where, in addition to looking at specific suggestions such as the ones before us today for fine tuning of the program, we have got to give increasing attention to the overall structure of the program itself, in order to make sure whether it is suitable for the long-term needs of the people that it is meant to benefit.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Gradison. I admonish all witnesses to proceed in your own manner. You may either hand in prepared statements and summarize them or you may read the prepared statement. But whichever you choose to do, bear in mind that it costs about 50 cents a word for you to do it. Please proceed.

STATEMENT OF PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY DENNIS FISCHER, DIRECTOR, BUREAU OF DATA MANAGEMENT AND STRATEGY; MICHAEL MAHER, DIRECTOR, OFFICE OF REIMBURSEMENT POLICY; STEVEN PELOVITZ, ACTING DIRECTOR, OFFICE OF RESEARCH AND DEMONSTRATIONS

Ms. FEINSTEIN. Mr. Chairman, I have a brief statement this morning I would like to read. I would also like to introduce the individuals accompanying me. Dennis Fischer, the Director of the Bureau of Data Management and Strategy; Michael Maher, on my extreme left, Director of the Office of Reimbursement Policy; and Steven Pelovitz, Acting Director of the Office of Research and Demonstrations.

We are pleased to be here today to discuss the medicare skilled nursing facility benefit. In my statement I will focus on the acute care nature of this benefit, the reason for the Department's opposi-

tion to removing the 3-day hospital stay requirement as a prerequisite to medicare coverage of skilled nursing care, and reimbursement issues.

As the subcommittee knows, when the medicare law was originally drafted, Congress decided to provide a posthospital "extended care" benefit to serve as an economical substitute for continued high-cost hospitalization. As this committee pointed out in its report in 1965:

> Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients.
>
> The posthospital extended care benefits which would be provided under the hospital insurance plan would cover care in qualified extended care facilities in cases where the patient was hospitalized for three or more consecutive days and then transferred to the facility for continued care of the same illness within 14 days of his hospital discharge.
>
> The hospital-transfer requirement is intended to help limit the payment of the extended care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following inpatient hospital care and makes less likely unduly long hospital stays.

As Congress intended, this benefit, now referred to as the skilled nursing facility benefit, has evolved as an extension of the hospital care that medicare covers for the aged and disabled. We believe that the original design of the skilled nursing facility benefit is valid today and we would not recommend a change in the nature of this benefit.

As you are aware, in the past 15 years health care prices have risen 1¼ times faster than prices in the economy as a whole. Every 6 years our spending for health care has doubled in this country.

In 1965, national health expenditures were 6 percent of the gross national product. In 1980, health care costs were 9.4 percent, or $247.2 billion. During this same period, Federal expenditures for health have risen from $5.5 to $70.9 billion to the point where 11.8 percent of the entire Federal budget is now spent on health care. In 1980, medicare spent $400 million for skilled nursing care, while medicaid, the major Federal source for nursing care funds, spent $10.3 billion—Federal and State—for skilled and intermediate nursing care services.

The Nation cannot tolerate these ever-rising costs, which, of course, include long-term care. All health care costs must be slowed down and brought under control. This administration is committed to this goal.

Demand for nursing home beds is steadily increasing because the number of elderly citizens is increasing. This creates pressures on the system because the bed supply is growing more slowly than the aged population. Thus, nursing home occupancy rates are high in most parts of the country and waiting lists for admission are often lengthy.

For example, between 1973 and 1977 the number of nursing home beds increased approximately 6 percent, while the number of persons over 65 years of age increased 12.7 percent. Occupancy rates of skilled nursing facilities averaged 89 percent nationally in 1977. In the same year, 81 percent of skilled nursing facilities reported that they had a waiting list containing an average of 25

names. While more recent data are not available, other evidence strongly supports the view that the shortage continues to exist. For example, there are widespread reports from State and hospital officials of difficulties in placing medicare and medicaid patients in nursing homes.

Less than 2 percent of medicare expenditures go for skilled nursing care. We believe that this percentage would not increase significantly, even if more skilled care beds are certified as medicare beds. The nursing home industry is geared toward care for the less acute, long-stay patient. The average medicare patient needs highly skilled care for only 28 days. Given a choice, a nursing home will fill a bed with a long-stay patient.

In 1977, the Health Care Financing Administration [HCFA] established two demonstration programs to investigate the consequences of eliminating this requirement for skilled nursing facility patients. I would like to point out that the primary focus of the demonstration was not cost, but quality of care. These demonstrations took place in Massachusetts and Oregon and were conducted by the Blue Cross plans of the two States. Approximately 30 medicare skilled nursing facilities in each State were granted waivers to provide covered services to beneficiaries without the precondition of the prior hospital stay.

HCFA contracted with a private firm—Abt Associates of Cambridge, Mass.—whom I believe you will hear from later this morning, to analyze and evaluate the data from the demonstration programs. The report by this contractor concluded that although waiver of the prior stay requirement led to a 10-percent increase in skilled nursing facility utilization, it did not produce a significant increase in total medicare costs.

According to the report, the cost attributed to increased skilled nursing facility utilization was offset by the savings from lower hospital utilization. This lower hospital utilization was, of course, attributed to the avoidance of the prior hospital stay by the waivered patients.

Based on the demonstration data, the private contractor estimated that removal of the 3-day hospital stay requirement nationwide in 1980 might have produced net program savings of $3 million. However, the contractor recognized that there were a number of uncertainties in the methodology that was utilized and stated that the net effect could range from a savings of $28 million to a cost of $13 million annually.

Moreover, it is important to note that this projection derives from a combination of the data from the two State demonstration programs. Taken separately, one of the State programs produced a net cost. The other State program reported a net savings; but after adjustments are made this savings is also transformed to a net cost.

When the study was submitted to HCFA, we had our Office of Financial and Actuarial Analysis evaluate the contractor's estimate. The actuaries advised us that, although the contractor had performed an analysis of the study data, its estimate had not adequately taken into account several important considerations.

For example, the contractor's estimate of decreased hospital costs of $49 million was calculated on the assumption that a day of hos-

pital care saved produced a savings equal to the per diem rate of the hospital. This assumption is not accurate for several reasons.

First, it does not recognize that even though a hospital bed may be empty, the hospital continues to incur many fixed overhead costs in maintaining that bed, and reimbursement for these costs is shared by medicare. In addition, the per diem rate assumed to be saved by the contractor includes ancillary services costs which would not be saved because a hospital patient who only requires a skilled nursing facility level of care would have lower ancillary services costs.

In their review of the relevant data, our actuaries found that there is no evidence that any significant number of beneficiaries are admitted to hospitals solely to meet the prior stay requirement for skilled nursing facility benefits. Thus the actuaries found that there would be no decrease in hospital utilization to offset the increase in skilled nursing facility utilization.

This means that there would be no savings in medicare program hospital costs to offset the increase in skilled nursing facility costs. This factor and several other considerations led the actuaries to estimate that the cost of eliminating the prior hospital stay requirement for fiscal year 1983 would be $60 million rising to $90 million by fiscal year 1987.

Mr. Chairman, it is primarily because of this substantial cost to the medicare program that we must oppose the proposed legislation to remove this requirement.

Again, unless the basic nature of the medicare skilled nursing care benefit is altered, I do not believe that changes in methods of reimbursement or administrative policies would bring about a significant rise in medicare skilled nursing facility utilization. We recognize that there are basic problems with the current medicare reimbursement system. Major industry complaints about this system are that it is retrospective, it requires detailed accounting procedures, and it does not provide a fair level of reimbursement.

This administration is philosophically opposed to retrospective cost reimbursement. The present system of cost reimbursement of hospitals and skilled nursing facilities for services provided to medicare beneficiaries stifles competition, carries with it the need for extensive Federal regulation, and is a major factor in the rapid growth of health care costs. In large part, the system of retrospective cost reimbursement has been one of the major contributors to the high rate of inflation.

We are working to design a system of prospective reimbursement, but this is a difficult and complicated process and it will take time to develop. We are working with a variety of both internal and external groups to develop new approaches to reimbursement, and we would certainly welcome this committee's advice and suggestions.

To summarize, we believe that the original design of the medicare skilled nursing facility benefit should not be changed. We therefore oppose removal of the 3-day hospital stay requirement which would alter the nature of this benefit and significantly increase the cost of the medicare program.

While I have only been able to provide limited comments on a very complex matter, the comprehensive study of the availability

and need for skilled nursing facility services mandated by Public Law 96-499 is currently under Department review. This study will give an indepth view of the current status of these facilities and the problems they face.

I will be happy to answer any questions you may have at this time.

Chairman JACOBS. Thank you.

Mr. Gradison.

Mr. GRADISON. Would your attitude toward this proposal be changed if at the same time that the prior 3-day stay in the hospital were eliminated, were modified by retaining the $260 deductible that we have today? That is to say, as I understand it, today you have got to have 3 days in the hospital before you go in the skilled nursing facility, and while you are there in the hospital you have got to pay the $260 deductible. If you could go right into the skilled nursing facility but had to pay the $260 as if you were in the hospital, would that affect your thinking about this proposal?

Ms. FEINSTEIN. You are saying if we took away the $260 deductible?

Mr. GRADISON. If you retained the requirement for the payment of the deductible, whether you went directly into the skilled nursing facility or had 3 days in the hospital first.

Ms. FEINSTEIN. No; I don't think that would change our thought. As we understand the medicare SNF benefit, it is an acute care follow-on benefit to being hospitalized. Under the statute, it must be treatment for the same condition for which you were hospitalized. I don't believe the presence or absence of the deductible would change our thoughts.

Mr. GRADISON. Are there any cases you know of, of situations where people have been put in the hospital in order to get those 3 days behind them when they really didn't need it as a means of getting in the skilled nursing facility? How much of that goes on? That is the main complaint we hear, is that we are utilizing the hospitals unnecessarily in such cases.

Ms. FEINSTEIN. We did a run of data rather recently on the number of patients who are in a hospital 3 to 6 days, a short stay, which would indicate that they were perhaps entering the hospital solely to qualify for the SNF benefit, and found that the incidence there was most negligible.

Mr. GRADISON. Does that suggest that there is no saving, that people are going to end up in the nursing facility one way or the other under medicare, no matter how we write the rules?

Ms. FEINSTEIN. What it suggests to us is that there does not seem to be a practice of individuals going to the hospital for a short period of time solely to qualify for the SNF benefit. We don't see that in the data.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Anthony.

Mr. ANTHONY. Thank you, Mr. Chairman.

I would just like some clarification on one of your comments. You have a paragraph in here where you make some fairly broad, sweeping, categorical statements without any supporting facts, and I just wondered if you would expound on that a little bit for me,

since I happen to be new to this committee and subcommittee. I have got to learn a little bit about what we are talking about here.

You are saying that you are opposed philosophically to the retrospective cost reimbursement, and then you even go on as far as to say that "It is a major contributor to the high rate of inflation."

I just wonder if you could expound on that statement.

Ms. FEINSTEIN. Basically, the way medicare reimbursement is set up today, there is no incentive for efficiency. It is retrospective, and it is cost based, and this administration would like to see us move toward prospective payment, where the providers know in advance what it is they are going to be paid for treating a patient in their facility.

This would eliminate much of the accounting requirements and forms that we now have, and in exchange we believe it would provide an incentive for efficiency. That is if they provide the care at less than the prospective rate, they can keep the difference.

Mr. ANTHONY. You are basically just saying if a patient has to go to a nursing home, admit that patient on the basis of the medical evidence. Later on, after you have done an audit, if you find that they have made some mistake, then you take whatever corrective steps would be necessary?

Ms. FEINSTEIN. That is what we do today. We essentially go in after the fact and look at all sorts of forms and data, and in a sense penalize efficiency. We would like to design a system that rewards efficiency in the industry. We believe the prospective payment will get us there.

Mr. ANTHONY. The State of Arkanasas only has two skilled nursing facilities. That is really not a big problem in our State. Our biggest problem is just nursing home beds, period. What would be the possibility of having some type of situation where the beds are not available but there are beds available in the hospital, allowing those people to stay in the hospital, reduce the services rendered to the level of services rendered in a nursing home, and drop the cost to the equivalent basis; wouldn't that save us some dollars too?

Ms. FEINSTEIN. We have a regulation in the final clearance process within HCFA now which would, in effect, "swing" beds that are currently acute care hospital beds, so that they can be used to provide long-term care benefits in the hospital setting.

We believe this will be particularly useful in rural areas, where access to medicare beds is more problematic than in some of the urban areas.

Mr. ANTHONY. You are talking my language now, since I represent a very rural area, and health care happens to be one of the greatest needs there. In writing your regulation, is it going to be so narrowly defined that just a few hospitals are going to be able to qualify, or is it going to be broadly written enough so that most of the hospitals could qualify?

Ms. FEINSTEIN. The legislation authorizing to write this regulation allows hospitals with 50 or fewer acute care beds to qualify for this benefit. Given that parameter, our intention is to make it as broad as we possibly can.

I would point out also that in our research and demonstration program, we are working with the Robert Wood Johnson Foundation in an urban area, swing-bed demonstration, and if the results

of that study is as positive as the studies in rural areas, we would expect to propose legislation to allow us to extend the swing-bed provision to urban settings as well.

Mr. ANTHONY. When you are talking about 50-bed hospitals, aren't we really talking about such an insignificant number that it is almost meaningless to try here? Of the 9,000 hospitals that we have nationwide, aren't there an insignificant number that are 50-bed or below?

And then I would like to know what is the status of the regulations, and when will they be proposed?

Ms. FEINSTEIN. The swing-bed regulations have been written. They are in the final clearance process within HCFA. I believe they will be published very soon.

Mr. ANTHONY. Are you saying that the 50-bed that the prior law, we would have to change the legislation?

Ms. FEINSTEIN. Yes; we would like to have the demonstration project results before we make that decision.

Mr. ANTHONY. Would you be supportive of that or do you want to wait and see what your demonstration project does?

Ms. FEINSTEIN. Yes.

Mr. ANTHONY. How come we have always got to demonstrate before we know what something good is?

Ms. FEINSTEIN. So that we have a better projection of the costs and effects of such a change.

Mr. ANTHONY. Thank you.

Chairman JACOBS. Mr. Rangel.

Mr. RANGEL. Thank you.

I assume that you discovered why it makes sense for a person that has been diagnosed as being in need of skilled nursing care by doctors, nurses, family, the community, the church, or the synagogue, that in order to get this care, that this person must spend 3 days in the hospitals, you have gone through the rationale of that?

Ms. FEINSTEIN. I believe so.

Mr. RANGEL. What did you say that you could tell us? This sick person, while it is abundantly clear that he or she needs to go to a skilled nursing home, that Washington mandates that you spend 3 days in a hospital, that can't help you?

Ms. FEINSTEIN. The benefit, as it was originally proposed, was designed to insure that the care received in the extended care component was for the same condition for which one was hospitalized. In effect, as we understand it, it was an acute care kind of treatment in a lower cost alternative setting.

Mr. RANGEL. Let me try again, because I know how the grand design is supposed to work and the cost savings, and I know we in the Congress try to do things for long-term gain, but I am just saying, how can we as part of government, and you, explain to the patient as to why he or she individually must be admitted to a hospital when all of the medical evidence is that they don't need any hospital care?

Ms. FEINSTEIN. The basic concept of the statute is that the care given in the skilled nursing facility be for the same condition for which the patient was hospitalized; it has never been intended to cover less serious conditions.

Mr. RANGEL. Let's try it again. It is clear that if the patient could have gotten to a hospital before this condition developed, that they would have gone, but at the point that the doctors are looking at the patient, it is clear that the patient needs skilled nursing home facilities, and we have been guilty in participating in the drafting of the statute and administration of the statute, now are faced with the patient, the doctor and the loved one saying that while it is abundantly clear that the patient should not be in the hospital, that the statute dictates and demands that they go for at least 3 days before they will be accepted in the skilled nursing home facility.

Ms. FEINSTEIN. This brings up the situation we are faced with—that is, the distinction between the long-term care benefit under medicaid, which is truly a long-term care benefit, and the long-term care benefit—perhaps inappropriately described—under medicare, which is essentially an acute care benefit involving recovery from a condition for which one was hospitalized.

Mr. RANGEL. I am just asking, could that condition exist outside of a hospital setting?

Mr. PELOVITZ. The data that we have on entry to nursing homes from hospitals does not show that that is a significant problem.

Mr. RANGEL. Well, that is good, because I don't want to deal with the data where you don't have a problem. We want to deal with the data that we have a problem, so that if that is not a significant problem, then perhaps you could assist us in remedying the law, so that we don't have to tell people who are home and sick and need skilled nursing home facilities that they have to check into a hospital before they check into a skilled nursing home. If it is no large number, maybe we can make the adjustments of the statute and move on.

Ms. FEINSTEIN. Mr. Rangel, I would just point out that when we looked at fundamentally changing the SNF benefit under medicare more in line with the medicaid long-term care benefit, our preliminary estimates were in the neighborhood of $5 billion. We believe that before we make that change, we ought to take a more global look at the entire benefit package.

Mr. RANGEL. Are both of you saying the same thing? I thought there was no significant constituency for this, so how would it be $5 billion?

Ms. FEINSTEIN. I am saying that, if the benefit is changed from its acute care nature, as it is now under medicare, to a more long-term benefit, as it is under medicaid, that the effect of that in terms of cost would be in the neighborhood of $5 billion.

Mr. RANGEL. Say that again. Five——

Ms. FEINSTEIN. Billion.

Mr. RANGEL. You mean if a person can leave a nonhospital setting, and be admitted to a skilled nursing home without the 3-day stay in the hospital, that it would cost the taxpayers $5 billion?

Mr. FISCHER. If the medicare benefit package were changed, and the skilled nursing facility benefit were altered so that it was not just a follow-on to an acute care situation, our preliminary estimate is that it would cost approximately $5 billion.

Basically, the change would put medicare in the long-term care business that is predominantly now medicaid, and there would be

some cost shifting over from medicaid to medicare. You would be changing a number of things; perhaps for example, eliminating the 100-day length of stay requirement. This would alter the whole nature of the benefit.

Mr. RANGEL. But when something costs the taxpayers $5 billion, could you describe what benefit would be connected with that $5 billion in terms of quality health care? I mean, you wouldn't say that would be a $5 billion waste?

Mr. FISCHER. I think the basic difference would be that under the current benefits package structure, medicare is aimed at an acute care episode. If a person goes beyond that and needs long-term care, our system is now constructed so that they are then covered under medicaid, if they meet the need test.

This $5 billion estimate is based on a restructuring that would, in effect, turn much of that around, and provide that medicare would now cover this care on an insurance basis, rather than having medicaid cover it on a need basis. I think that is where we believe we should look at the entire benefit package structure of both the medicare and medicaid programs, to see what is the proper mix.

Mr. RANGEL. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions. Thank you, Mr. Chairman.

Chairman JACOBS. Ms. Feinstein, do you think you are short-handed at HCFA? Do you think the administration has cut down on your personnel overzealously? Do you think you have enough people to keep up?

Ms. FEINSTEIN. Currently, we do.

Chairman JACOBS. Do you? The reason I asked the question is that you are not current on some of the requirements by law. For example, the indepth study to which your prepared statement refers I believe was due on December 5. If you have enough people to do it, are they goofing, or what is the problem? Too much red-tape? Too many people have to sign off on it?

Ms. FEINSTEIN. The study is being cleared in the Department right now. I expect it will be up within the month.

Chairman JACOBS. I have only heard tangentially what goes on. If you say that is a squirrel, nine other people have to look at that sentence and decide that it was OK to say that was a squirrel, even people that didn't see the animal; isn't that about the problem you face over there in the bureaucracy?

Ms. FEINSTEIN. Some of that occurs is very true.

Chairman JACOBS. I asked for the record also about three other requirements of the department that seem to be somewhat overdue. One is a regulation to implement section 933 of Public Law 96-499, comprehensive outpatient rehabilitation facility services. I believe that was to have become effective on July 1, 1981. What can the public expect in terms of completing that regulation?

Ms. FEINSTEIN. The regulations on comprehensive outpatient rehabilitation facilities?

Chairman JACOBS. Yes.

Ms. FEINSTEIN. That also is in departmental review.

Chairman JACOBS. Is this the Peter principle or something? Do you think it is OK the way it is now? They don't come out all that

great after all these people work on them. Then the next one that we have listed here, regulation to implement section 934 of Public Law 96-499. That is the outpatient surgery. I don't believe I know exactly when this was due. Is that overdue?

Ms. FEINSTEIN. Yes; it is.

Chairman JACOBS. What might we expect in connection with that?

Ms. FEINSTEIN. We are working on some of the cost estimates even as we speak. I expect that that, too, will get out very shortly.

Chairman JACOBS. I think you could write a novel.

Finally, a study required by the 1981 Reconciliation Act to determine the continued need for dual cost caps for free-standing and provider-based home health agencies. I think that was due the first day of January 1981, and I believe I have written to Dr. Davis about that some time ago. I am not sure I really have an answer to that letter yet. I think I wrote that letter on December 23.

What is the status of that study?

Mr. MAHER. We have just completed examining about 280 cost reports and are just wrapping that study up. We have drafted the reply to your letter, and you should get that shortly. We will be using that information when we put out the new set of limits that are due out later this year.

Chairman JACOBS. Thank you. I yield to the gentleman from Tennessee.

Mr. DUNCAN. Ms. Feinstein, your operating budget or the funds that you have this year, how does it compare with the last fiscal year in dollars?

Mr. FISCHER. Sir, we have a number of categories of our operating budget. I presume that you mean our operating costs as opposed to benefit costs.

Mr. DUNCAN. Out of the entire budget, it is more, isn't it?

Mr. FISCHER. No, sir, for the cost of running the Health Care Financing Administration, 1982's level is a decrease of $6 million, down to $177 million from the 1981 level.

Mr. DUNCAN. Is that your entire budget?

Mr. FISCHER. No, sir, that is for the administrative costs, for Federal employees. There are a number of other categories, administration of medicare, which is done——

Mr. DUNCAN. What about the entire budget, the other categories? I know when we are asked to cut, we never are asked to cut the administrative costs. We usually are asked to cut down where it hurts the people.

Mr. FISCHER. The total administrative costs, from 1981 to 1982, for the Health Care Financing Administration have gone down approximately $50 million.

Mr. DUNCAN. Has that gone down on your request or the amount of money you had this fiscal year? You know the difference in reducing the request and reducing the money you had?

Mr. FISCHER. Yes.

Mr. DUNCAN. Most people are talking about requests these days instead of what they spent last year.

Mr. FISCHER. No, sir, that is against what we actually spent last year. The majority of that decrease is in the PSRO program, Professional Standards Review Organizations, for which the funding

was cut back primarily to correlate with the changes that were made by Congress in the 1981 Budget Reconciliation Act concerning PSRO reviews under medicaid. It also reflects the elimination of inefficient PSRO's.

Mr. DUNCAN. Thank you very much. Thank you, Mr. Chairman.

Chairman JACOBS. Yes, sir.

Ms. Feinstein, one other question. In answer to an inquiry from Mr. Anthony, you said a moment ago that you did not want to express a view on the question until the demonstration project had been completed. Yet, as I understand your testimony, and the conclusions of the actuaries, demonstration projects really don't count for much anyway, do they? The Abt studies, for example, were they worth what you paid for them?

Mr. FISCHER. Sir, since I am the person responsible for the actuaries, I will try to respond to that. There are two pieces of the Abt evaluation. We found that the work that they did in trying to forecast how much the skilled nursing facility benefit cost would increase to be very consistent with ours, and the data that they found was quite useful, even though, as I believe we indicated earlier, the purpose of the demonstration was to demonstrate quality, not cost.

Where we differed was what we felt the effect would be on hospital costs, and for reasons which I think we outlined in the testimony we did not feel that was applicable.

I wouldn't interpret that to mean that the demonstration effort and the evaluation of it was a wasted effort simply because we came to different conclusions.

Chairman JACOBS. I am a little confused as I read it. I see here again, that study estimated—I don't know where they got the word extrapolated; it may be in the dictionary by now; I don't think it means anything—that there would be a savings of as much as $28 million, some say as little as $3 million, but nonetheless something on the positive side. If I understand correctly, you people decided that it would be just the reverse and a very substantial loss?

Mr. FISCHER. Yes, sir.

Chairman JACOBS. The main thing we wanted to know from that demonstration project, from the Abt study, was whether we ought to go ahead and do it. Now you sound like the pollster who told the candidate, "You are losing," when the candidate said he didn't like it, the pollster took his eraser out and said, "We will put down 60–40 the other way, if you prefer."

Mr. FISCHER. We are not able to express estimates in a range, we have to put down a specific number.

Chairman JACOBS. Is it ever right?

Mr. FISCHER. Yes, sir, I think that the track record of our actuaries is certainly the best in town, and accepted as such.

Chairman JACOBS. Let me ask you a question about that. I find that somewhat puzzling. I don't know whether you are talking about just medicare actuaries or the social security system generally, but it seems to me the other day when the Senate was considering the minimum benefit legislation there was one set of actuarial prognostications before they acted and by the time it got over to the conference committee, there was a brand new set showing the sky had fallen. That was in the space of about, what, 10 days?

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Mr. FISCHER. I believe the actuaries that made those estimates are in the Social Security Administration, not the Health Care Financing Administration. I would stress, though, sir, that the actuaries make estimates, and they are just that—they are estimates. They represent our best professional judgment.

Chairman JACOBS. You are always right. You said you are almost always right?

Mr. FISCHER. We feel we have a very good track record of being accurate, but we would never say the results came out exactly as we estimated.

Chairman JACOBS. I don't mean really to quibble, but you say it was the other guy, and yet the change in the figures was in the medicare expectations. The medicare trust fund expectations, that is where the change came suddenly, within 10 days. I don't like to quibble.

Mr. FISHER. Sir, I am sorry, I now recall what you are referring to. We make our actuarial estimates based upon the latest trend data that we have. When we worked on the minimum benefit issue, we received some new trend data which showed hospital inflation was running at 16 percent rather than what had been projected, which was approximately 13 percent.

That was the reason for the increased estimate on the medicare benefit side. That percentage change was factored into it.

Chairman JACOBS. Some of us were very confused by that because we really thought this administration would bring inflation down, not an upsurge. I have one last question. A voice keeps telling me I have one last question.

The last question is, I think Chairman Rostenkowski wrote to Ms. Davis some time back about nine specific studies and reports which your department was to have supplied this committee prior to January 1, 1982, none of which have been received. I won't enumerate them. Are you familiar with that correspondence?

I guess the question is, how soon will we at least get the answer to Mr. Rostenkowski's letter?

Ms. FEINSTEIN. I am not familiar with the piece of correspondence, but I would be happy to submit for the record when you will receive the reports.

Chairman JACOBS. Great.

If there are no further questions, the subcommittee is grateful to the administration for its participation in these hearings. We thank you.

Ms. FEINSTEIN. Thank you.

Chairman JACOBS. The next witness is the Honorable Ron Wyden, Representative in Congress from the State of Oregon.

We welcome you, sir, our colleague, to the subcommittee and invite you to proceed in your own manner.

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WYDEN. Thank you very much.

Mr. Chairman, for the record I am Representative Ron Wyden, representing Portland, Oregon. I in particular want to start by expressing my appreciation to you, Mr. Chairman, for being willing

to hold this hearing. I think in particular when you are a freshman in this place, as I am, you appreciate someone taking the time that you have to give me a hand with this bill. I am grateful for it; also, to a number of colleagues on both sides of the aisle for their help.

I will make a very short statement and then field any questions.

For 7 years before I came to the Congress I worked with senior citizens in a legal program for older people. I served a term as public member on the Oregon Board of Nursing Home Examiners.

I taught gerontology at Portland State University and the University of Portland and, based on this kind of experience, I came to feel that there really aren't any issues that are more important to this country's elderly than the need for high quality, affordable nursing home care.

Because of that interest, I came here today to urge you to adopt legislation, H.R. 4227, that I recently introduced that would stabilize, cut back on needless regulations and save money, all by eliminating the current requirement that medicare beneficiaries spend three days in the hospital before they can be eligible for medicare skilled nursing facilities benefits.

I got interested in this issue in particular because a constituent of mine was suffering from terminal pancreatic cancer and entered the Portland Adventist Medical Center in Portland, Oreg. last year complaining of uncontrollable pain.

She entered the hospital rather than a nursing home for just one reason; that is, the 3-day prior hospitalization rule. Although she needed medical supervision and observation unavailable in her own home, her physician said she could have received the necessary care at a skilled nursing facility.

This woman was hospitalized from Friday until Wednesday. On Wednesday a bed was located in a skilled nursing facility, to which she was tranferred. She was weakened by the move, and she died about 2 hours after the admission.

I would like to be able to tell the committee that this is an isolated case. Sadly, it is just not so. Doctors, nurses, health professionals, and senior citizens have told me story after story about the human tragedies that result from the enforcement of the 3-day requirement.

With that kind of evidence, they continually cite needless paperwork and wasted money that is incurred in enforcing this rule. That is why health care providers, as well as senior citizens, are seeking the repeal now of the 3-day requirement. That is why my legislation today has 60 cosponsors from both sides of the aisle in the House, and today enjoys broad-based support from groups that range from a variety of senior citizens organizations to the American Medical Association.

The benefits of this legislation are clear, it seems to me.

First, we are able to obtain greater flexibility and freedom of choice in patient placement for doctors and patients.

Second, we can eliminate transfer trauma for patients hospitalized only to meet the 3-day requirement and, at the same time, remove the needless and time-consuming paperwork that such transfers entail.

Third, a cost savings realized by allowing patients to be cared for in skilled nursing facilities rather than in more expensive hospitals is an obvious benefit of this kind of legislation.

I don't make these claims lightly. In particular, I think we have got to look at the cost factors.

When I introduced this legislation, I knew that the Health Care Financing Administration had funded a successful 3-year study in Oregon on the impact of eliminating the 3-day requirement.

In September, the evaluators of that study, Abt Associates, presented the formal results of that study and a similar study that was done in Massachusetts and in effect confirmed what I had already been told.

The results are clearly positive, both in terms of quality of care and in terms of cost saving. In fact, Abt Associates calculated, using what they call specifically their best estimate, an overall savings of $3 million nationwide had this waiver been in effect in 1980.

I was delighted with these results because they confirmed, of course, what senior citizens, physicians, and nursing home administrators had been saying for years; that is, that it doesn't make sense to hospitalize a patient if the patient can receive the proper level of care in a skilled nursing facility. It is just not humane. It is just not cost effective.

Knowing that kind of evidence, you can imagine how absolutely stunned—I guess stupified would be a better word—I was to learn later that now HCFA actuaries are calculating, as they have repeated again today, that the elimination of the 3-day requirement would cost $60 million in 1983.

The question really is how can there be such a discrepancy in cost estimates between the HCFA actuaries are calculating and Abt Associates. This was a study commissioned and directed by HCFA, and when you ask them what had gone wrong, you really hear two things.

First, the HCFA actuaries claim that they didn't factor in any cost savings from not hospitalizing patients. They cite in particular the problem of cost-based retrospective reimbursement, where they argue that medicare will still end up paying for those empty beds anyway.

Mr. Chairman, this argument just astounds me. I can't believe that HCFA would now advocate that we make it a formal public policy to keep hospital beds in this country full just because Medicare is going to pay for them. That logic is just absolutely perverse.

Mr. Chairman, if Congress buys that argument, we are going to be the laughing stock of citizens who are trying to make a genuine effort to do something about the incentives in our health care system, particularly at a time when we seem to devalue just about all the medical alternatives in this country except hospitalization.

It will also have based our decision, in my opinion, on a very peculiar set of assumptions. In other words, for medicare to pay even a proportion of the cost of beds left unoccupied due to elimination of the 3-day requirement one would have to assume almost automatically that the bed actually remained empty. Now, in some hospitals perhaps this is true. In others it obviously is not.

One would also have to assume that medicare would pick up the costs of that bed, a factor which again depends entirely on how many medicare patients that hospital served.

A second factor in the discrepancy between the HCFA actuaries' estimates and those of the Abt study is the actuaries refusal to believe that patients enter hospitals solely as a result of the 3-day requirement.

The actuaries there based their assumption on the number of 3-day or short-term medicare hospital stays. They say there is just no large demand for the 3-day stay.

Mr. Chairman, this doesn't really surprise me. Once a patient is hospitalized, the chances of him or her ever being transferred to a nursing home, obviously, becomes less certain. But at the same time, based on working with senior citizens, we know that patients are hospitalized to fulfill the 3-day requirement.

We didn't bring the charts or the graphs here today to prove that point, but if we would like to have another session, we can just have witness after witness representing a wide variety of professional associates—doctors, nursing home administrators, and senior citizens—who can tell you that that does actually happen and happens just too often.

I can't, as you can obviously see, agree with HCFA's cost estimates as we have heard them today. If anything, I think that Abt Associates used very conservative figures in their evaluation.

I think we have got reason to believe that there are even greater cost savings involved in my legislation than Abt predicted. For example, there would be savings under part B for physician visits, and I think there would also likely be savings to home health care services. These were noted by Abt Associates but these savings weren't even factored into their final cost estimate, which showed that we would save $3 million a year.

Legislation that I propose has just one purpose; that is, to encourage proper and humane utilization of our health care resources. To let this objective get bogged down in a discussion over the appropriateness of retrospective cost-based reimbursement in my opinion would be a step backward and, in particular, it would be a slap in the face to all those who participated in the 3-year demonstration. It also means that we just threw in the trash can 750,000 dollars worth of the taxpayer's money on another study that is just going to be ignored.

I would also like to add, Mr. Chairman, that the idea for cost-based hospital reimbursement was not exactly born yesterday. I find it hard to believe that evaluators of these studies weren't told how to evaluate the hospital reimbursement savings.

I really can't understand why HCFA funded a study if it had actuaries who could have told us 3 years ago no matter how many medicare patients were treated in a less costly facility, HCFA won't save any money because medicare still picks up the tab for the empty hospital beds.

I am very much aware of the problems associated with retrospective cost-based reimbursement. In fact, I have introduced another piece of legislation, H.R. 5084, which deals with this problem by giving hospitals in this country incentives, not using a straitjacket

approach, but giving them incentives to go to a prospective reimbursement system.

I do want to emphasize for the purpose of today's hearing that hospital reimbursement is a very different and separate issue from the health care question epitomized by the elimination of the 3-day prior hospitalization requirement.

In conclusion, Mr. Chairman, I would like to stress once again what we are really talking about here. We are not just talking about statistics, about numbers that are just shuffled around on some kind of tally sheet. We are talking about suffering. We are talking about suffering by senior citizens, seniors that are traumatized for the sake of a ridiculous regulation, a regulation that only costs us money and precious staff hours.

In virtually every respect, the issue that we are dealing with is the Katie case revisited in Iowa. All of you are familiar with that case, where the President personally helped intervene in the case of a young woman to receive treatment outside of a hospital where the Government in effect mandated hospital care.

I would submit to you that the issue we are to deal with today is essentially the Katie case revisited.

I urge the distinguished member of this committee to just say no to this kind of bureaucratic stupidity. The requirement that a patient be hospitalized for 3 days before receiving skilled nursing care is inefficient and an inhumane way of allocating our resources.

We have talked and discussed eliminating this problem for 10 years. It has been studied now for 3. The studies are clearly positive. I hope and urge you that we can take action at this time.

Thank you.

[The prepared statement follows:]

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

HUMANE AND COST-EFFECTIVE HEALTH CARE FOR SENIORS

Mr. Chairman, I commend you for holding this hearing today. Based on my 7 years of experience working with senior citizens and my term as the public member of the Oregon Board of Examiners of Nursing Home Administrators, I can assure you that few issues are more critical for America's elderly than the need for high-quality, affordable nursing home care.

I came here today to urge you to adopt legislation I recently introduced which would save lives, cut back on needless regulations and save money—all by eliminating the current requirement that Medicare beneficiaries spend 3 days in the hospital before they can be eligible for Medicare skilled nursing facility benefits.

Let me explain. Last year a constituent of mine who was suffering from terminal pancreatic cancer entered Portland Adventist Medical Center in Portland, Oregon complaining of uncontrollable pain.

She entered the hospital rather than a nursing home for only one reason—the 3-day prior hospitalization rule. Although she needed medical supervision and observation unavailable in her own home, her physician said she could have received the necessary care at a skilled nursing facility.

This woman was hospitalized from Friday until Wednesday. On Wednesday, a bed was located in a skilled nursing facility to which she was transferred. Weakened by the move, she died 2 hours after admission.

I would like to be able to report that this is an isolated case. Unfortunately, it is not. Doctors, nurses, health professionals, and seniors have told me story after story about the human tragedies which have resulted from enforcement of the 3-day requirement. They have also told me about the needless paperwork and wasted money that have resulted.

That's why health care providers as well as seniors have sought repeal of the 3-day requirement for years. And that's why today my legislation has 60 cosponsors and enjoys broad based support from groups ranging from numerous senior citizen organizations to the AMA.

The benefits of my legislation are clear:

(1) Greater flexibility and freedom of choice in patient placement for doctors and patients.

(2) Elimination of transfer trauma for patients hospitalized only to meet the 3-day requirement—and the needless and time-consuming paperwork that such transfers entail.

(3) A cost savings realized by allowing patients to be cared for in skilled nursing facilities rather than in more expensive hospitals.

I do not make these claims lightly. Consider the cost factor. When I introduced this legislation, I knew that the Health Care Financing Administration (HCFA) had funded a successful 3-year study in Oregon on the impact of eliminating the 3-day requirement.

In September, the evaluators of that study, Abt Associates, presented the formal results of that study and a similar Massachusetts study—and confirmed what I had already been told. The results were positive—both in terms of quality of care and cost-savings. In fact, Abt Associates calculated an overall savings of $3 million nation-wide had this waiver been in effect in 1980.

I was delighted with these results because they confirmed what the senior citizens, physicians, and nursing home administrators had been telling me for years—that it does not make sense to hospitalize a patient if that patient can receive the proper level of care in a skilled nursing facility. It is inhumane and not cost-effective.

Thus, you can well imagine how stunned I was to later hear that HCFA actuaries had since calculated, as they told you today, that the elimination of the 3-day requirement would cost $60 million in 1983.

How could there be such a discrepancy in cost estimates between the HCFA actuaries and Abt Associates? This was s study commissioned and directed by HCFA. What had gone wrong?

The explanation is two-fold.

First, the HCFA actuaries did not factor in any cost savings from not hospitalizing patients. Their rationale? Due the nature of cost-based retrospective reimbursement, Medicare would end up paying for those empty beds anyway.

Quite frankly, Mr. Chairman, this argument astounds me. I just can't believe HCFA would advocate we make it a public policy to keep hospital beds full just because Medicare will pay for them. That logic is, at best, perverse.

Mr. Chairman, if Congress buys this argument it will become the laughing stock of citizens who are making a genuine effort to do something about the incentives in our health care system which today devalue all alternatives except hospitalization.

It will also have based its decision on a very peculiar set of assumptions. In order for Medicare to pay even a proportion of the cost of beds left unoccupied due to elimination of the 3-day requirement, one would have to assume the bed actually remained empty. In some hospitals this might be true. In others, it would not.

One would also have to assume that Medicare would pick up the costs of that bed—a factor which would depend entirely on on how many Medicare patients that hospital served.

A second factor in the discrepancy between the HCFA actuaries' estimates and those of the HCFA-sponsored study was the actuaries' refusal to believe that patients enter a hospital solely as a result of the 3-day requirement.

The actuaries based their assumption on the number of 3-day or short term Medicare hospital stays. They say there is no large demand for the 3-day stay.

Mr. Chairman, this doesn't surprise me. Once a patient is hospitalized, the chances of him ever being transferred to a nursing home become less certain. However, as a long-time senior advocate, I know patients are being hospitalized to fulfill the 3-day requirement. I have no charts or graphs with me here today to prove my point. But if you wanted, I could produce a long line of witnesses—of doctors, and nurses, and nursing home administrators, and seniors—who could tell you that it happens—and that it happens far too often.

Mr. Chairman, I cannot agree with HCFA's cost estimates as you have heard them today. If anything, since Abt Associates indicate they consistently used conservative figures in their evaluation, there is reason to believe we might realize even greater cost-savings than Abt has predicted. For example, there would be savings under Part B for physician visits and there would most likely be savings from

home health services. Although noted by Abt Associates, these savings were not factored into their final cost estimate.

My legislation has one purpose—to encourage proper and humane utilization of our health care resources. To let this objective get bogged down in a discussion over the appropriateness of retrospective cost-based reimbursement would be a step backward—and a slap in the face to all those who participated in this 3-year demonstration. It would also mean we wasted $750,000 in taxpayers' money on yet another study which will sit on a shelf gathering dust.

I might also, add, Mr. Chairman, that the idea for cost-based hospital reimbursement was not born yesterday. I cannot believe the evaluators of these studies were not told how to evaluate the hospital reimbursement savings. And I cannot understand why HCFA funded a study if it had actuaries who could have told us 3 years ago that no matter how many Medicare patients were treated in a less costly facility, HCFA wouldn't save any money because Medicare still pick up the tab for the empty hospital beds.

I recognize the problems associated with retrospective cost-based reimbursement. In fact, I have introduced legislation which deals with this problem by changing hospital reimbursement to a prospective system. However, I want to emphasize again that hospital reimbursement is a separate issue from the health care issue epitomized by the elimination of the 3-day prior hospitalization requirement.

In conclusion, Mr. Chairman, I would like to stress once again what we're talking about here. We're not merely talking about numbers shuffled around on a tally sheet. We're talking about human suffering—human beings that are traumatized for the sake of a ridiculous regulation—a regulation that only costs us money and precious manhours.

I urge the distinguished members of this committee not to tolerate this kind of bureaucratic stupidity any longer. The requirement that a patient be hospitalized three days before receiving Medicare skilled nursing services is an inefficient and inhumane way of allocating our resources.

Its elimination has been discussed now for ten years. It has been studied for three. The studies were positive. It is time now to move.

Chairman JACOBS. I was going to say very eloquent, but I will add the words "very poignant".

Mr. Anthony?

Mr. ANTHONY. Thank you, Mr. Chairman.

Back home, if we were on the other side of your position, we would call you undecided.

I think you make a very strong point. I must admit that it gives me a great deal of frustration, too, when we set up demonstration projects and then we disregard the findings of those demonstration projects.

It appears to me that sometimes we disregard the findings of those demonstration projects because it has to fit within the neat realms of the policies that have been developed in the heirarchy above by the bureaucrats that are trying to adequately run the programs.

That additional layer of bureaucratic policymaking seems to me to hit directly at this particular problem. They are trying to find a way to cut—and when I say they, I am talking about the administration—they are trying to find a way to cut medicare and health care services rather than extend any additional benefits.

If I understand the testimony correctly from the previous panel, they are not really worried about anything but changing the nature of the benefit, that it would become a redefined benefit under medicare, and they are just not willing to get into that.

This committee is going to have to resolve conflicting testimony between a $60 million cost in 1983 versus a several million dollar savings.

How are we going to resolve the conflicting testimony?

Mr. WYDEN. I have two points, as far as my colleague's question, both of them good.

First, with respect to the administration's attitude, I am very concerned—and it is not just in the administration—that what we talk about in medical care is a butcher block approach. All we do is talk about huge cuts rather than what I have tried to do with this bill and my other bill on prospective reimbursement, which is to look at the best allocation of resources.

I in particular appreciate the committee's leadership in this area because this is really the question. We just go with butcher block approaches. Maybe we will save $1 at some place in the system, but we are going to end up spending more dollars later down the road. I just hope we look at these kinds of approaches in this bill, and others, which allows us to allocate our resources in the best possible way.

Now, with respect to making a decision about the Abt experiment or the appraisal of the HCFA actuaries, I would urge you to go with the current best estimate. That is Abt associates. They were commissioned to do this work by HCFA. It is the most current study available. We spent $750,000 of taxpayer's money. I can't for the life of me figure out why that doesn't count a whole lot more than a lot of these other appraisals that are essentially based on older data, more outdated kinds of assumptions.

Abt's analysis is the most current, and I would only say to my colleague, I think that all of us understand that it just makes commonsense. You don't really have to be a wizard, some kind of medical care genius, to understand that it is smart to make available the option of skilled nursing home care that costs less than a nursing home bed.

So, I think you combine commonsense plus the most current definitive analysis available, and I think you could with Abt.

Mr. ANTHONY. What you would do then is encourage this committee to base its judgment on that study that we bought and paid for, put it into place, and then let history judge who is right and who is wrong.

If we are right, we can go back and say that we are right. If we are wrong, then we can come back and undo it.

Mr. WYDEN. I think history is going to show that you are right, but I would tell my colleague just one thing. No matter what decisions we made in this institution about the future of medical care, whether we go to competition bills or tax caps or anything else, one thing that is always going to make sense is trying to choose appropriate levels of care. That is what this bill involves, and that only.

Let's not perpetuate a system that really dictates inappropriate levels of care. I think that eliminating this 3-day rule so we can get a handle on what is the appropriate level of care in treating senior citizens with these kinds of problems makes sense no matter what we do. Whether we go to our colleagues, our competition method, a tax count method, vouchers or any of those kinds of things, this bill is consistent with all of those approaches.

Mr. ANTHONY. Thank you very much.

Chairman JACOBS. Mr. Gradison?

Mr. GRADISON. Mr. Chairman, I really don't have any questions. Our colleague's statement was excellent and very clear, but I do want to thank him for his leadership on this issue.

I guess as I listen to the testimony, I am wondering whether there is some way to make this change but still protect the program if the costs—who knows—do turn out to run higher than Abt indicates.

Possibly there are some other related savings that we could combine with this, perhaps reducing the number of days which medicare, at the end of a stay, would reimburse the skilled nursing facilities for or applying the copayments that would be required if a person were in the hospital so as to cover the $50 or $60 million, and if it turns out that that is not necessary, those benefits could be restored.

I mean, there are two ways to do this. One is to go in and say it isn't going to cost any money and therefore we are going to simply make the change. Another is to say it might cost some money, so let's put in some cost savings to balance this logical change. The change is logical. The question is, What is it going to cost, if anything?

I don't question anybody's motives. I am sitting here and I am hearing two responsible groups give me different numbers. Being a cautious person, my inclination is to say OK, the change is logical, but if it turns out to be expensive, can't we incorporate in this change some ways to protect ourselves.

I think there are some, and I hope that we will be able to explore these in the course of this hearing.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Rangel?

Mr. RANGEL. Thank you.

I want to join with my colleague, Mr. Gradison, in congratulating you for the leadership that you provided in this area. I assume you came to the Congress in order to try to improve the quality of health care and also to try to contain the ever-inflating cost of health care in our Nation.

I don't know whether you met the new administration's guidelines as to how we intend to legislate in the future; that is, is this consistent with getting the Federal Government out of the lives of people and can this effectively be transferred to local and State government.

The fact that it saves money and makes sense is not really a question for this administration.

Mr. GRADISON. Would the gentleman yield?

Mr. RANGEL. Yes.

Mr. GRADISON. I am not sure I understand your point. My understanding was that the administration suggested in the health field federalizing medicaid as well as medicare. Is that not correct?

Mr. RANGEL. Yes, it is for the trust fund that depends on the windfall profit tax, for which we don't know how long we will have it.

Mr. GRADISON. No—if the gentleman will yield further—I think you may have two concepts confused. The financing of the medicare takeover is totally unrelated in the concepts that have been

presented so far to us by the administration from anything having to do with these excise taxes.

The excise tax under present law—the excise tax on oil would expire. The other excise taxes which the administration has suggested putting in this trust fund would also be permitted to end at the Federal level around 1991.

But just as a factual statement, to my knowledge there is no connection that has been suggested between revenues from any single source and the willingness of the Federal Government under the recommendations of the administration to take over medicaid.

I am not suggesting it is a good or a bad idea, but with regard to what their proposal is, I just want to clarify my understanding of it.

Mr. RANGEL. I am glad you did because I really thought that the thrust was for the Federal Government to collect taxes and to be able to declare war. I got the clear impression in taking care of people and those types of services it was local in nature.

Mr. GRADISON. If the gentleman will yield further, I will say that they are anxious to declare war on medical costs and are willing to get involved in a very high-risk strategy to do it; high risk in this sense, that those who are in support of let's say national health insurance should enthusiastically—I mean this sincerely—support the notion of federalizing medicaid because it is a step in that direction.

The gamble this administration is taking is that by having Federal control over both medicare and medicaid it will be possible to institute major changes in the methods of financing health care and try to change the reimbursement system and change the way in which costs are driven upward as a means of trying to control them.

Whether they prove correct or not in this approach, the very fact of federalizing medicaid would be a step toward a national health insurance scheme.

I think that it is important in looking at what they are recommending to realize that from the point of view of the long-term objectives of this administration, that is a very high-risk strategy for an administration which is philosophically opposed to national health insurance.

Mr. RANGEL. I just never read anywhere that medicaid was going to be a Federal responsibility on a long-term basis. I thought that was merely a temporary gesture, and I had no idea that the administration intended to merge the two and would include that as a part of our national policy because if that was so, a lot of Governors are frustrated for naught.

In any event, health care isn't high on our priority and commonsense doesn't normally prevail when we get to the budgetary questions, but we all have to make certain that we do the best that we can.

I do hope, Mr. Chairman, that with some of these very key issues that we not find ourselves as we did the last time—that is, just voting up and down on one big package—and that we are able to give this matter the consideration it deserves.

Thank you.

Chairman JACOBS. I do note that the martial language has been abundant—war on high cost, war on waste—and maybe it just could be, Mr. Rangel, the way we can come at this thing and really make some quantum leaps is to term it a war on illness. God knows what miracles would happen if you use the right words.

Mr. RANGEL. If old age is communistically inspired, we can have another rout on these systems.

Chairman JACOBS. That is a thought.

Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman. I am glad to get back to the subject at hand. What was the subject?

Chairman JACOBS. Whatever it was, the gentleman is clearly out of order.

Mr. DUNCAN. As Mr. Rangel says, I am at least not frustrated, like so many Governors are frustrated, anyway.

I would like to thank our colleague. I talked with him on this particular subject. I think his aspirations are pretty much the same as all of ours. If it doesn't cost anymore, I think that is the thing we must be interested in.

I was wondering if you had given study to the utilization factor, whether or not we would have more or less by bypassing the 3-day hospital stay.

Mr. WYDEN. That was incorporated into this study appraisal, would additional numbers of older people go to skilled nursing homes as opposed to hospitals. I am satisfied that all the factors were taken into consideration, with the possible exception of this question of are we going to reward hospitals for empty beds, which is a factor involved in this.

I do not think that we are going to be tilting the whole system now to skilled nursing facilities, and I in particular would cite the fact that the requirements for skilled nursing homes are very, very strict. It is not exactly a Pandora's box full of opportunities for waste and fraud and abuse. It is a very strictly run program.

I think my colleague may be aware that a very small fraction of the nursing home patients in this country, a very, very small fraction, are even in skilled nursing homes. Most of them are in what are called intermediate homes. I don't think that there is a great possibility for those who want to take advantage of the system to use this kind of change to do so.

Mr. DUNCAN. I agree with you that skilled nursing homes do have a great deal of credibility.

Mr. Chairman, I yield back the balance of my time. Thank you.

Chairman JACOBS. Mr. Wyden, the committee is grateful to you. You have been very concise and very persuasive. You done good.

Mr. WYDEN. Thank you, sir.

Chairman JACOBS. The next witness is Howard Birnbaum, Director of Aging and Public Programs, Cambridge, Mass.

Mr. Birnbaum, you know the rules of the New York State Athletic Commission. Proceed in your own way.

STATEMENT OF HOWARD BIRNBAUM, DIRECTOR OF AGING AND PUBLIC PROGRAMS, ABT ASSOCIATES, INC., ACCOMPANIED BY SALLY STEARNS, PROJECT DATA BASE MANAGER, AND RACHEL SCHWARTZ, DEPUTY PROJECT DIRECTOR

Mr. BIRNBAUM. Mr. Chairman, I am Howard Birnbaum, Director of Aging and Public Programs at Abt Associates.

The major issues about which I am pleased to provide testimony involves the cost of the prior hospital stay. At the end of my remarks, I will also comment briefly on some of the other issues involved in nursing home reimbursement. However, I would first like to introduce these comments.

For the last 7 years, I have been involved in evaluative studies and research for the Department of Health and Human Services—and its predecessor, the Department of Health, Education, and Welfare—including several projects for the Health Care Financing Administration, HCFA.

These studies have considered a variety of issues affecting both acute and long-term care, as well as several associated income security programs.

It is my involvement as director of a recently completed study for HCFA on the prior hospital stay requirement that brings me here today. Sally Stearns and Rachel Schwartz, who are with me, also were involved in this study.

Although expenditures for skilled nursing care are less than 2 percent of the total medicare budget, medicare patients may enter the hospital and incur unnecessarily expensive hospital stays because of entry requirements for the medicare skilled nursing care benefits.

One possible response that has been under congressional consideration for the past decade is the elimination of this requirement. In 1977 the Health Care Financing Administration established demonstration programs in Massachusetts and Oregon to provide information on this issue.

Two years later, in 1979, HCFA contracted with Abt Associates Inc., to conduct an independent evaluation of these direct entry options. The key results from the evaluation,[1] completed this fall, are:

First, direct entry SNF patients accounted for approximately 10 percent of the covered medicare SNF admissions to participating demonstration SNF's. The dominant constraints on direct entry utilization were the effective strictness and enforcement of the medicare criteria governing admissions to SNF care. Those criteria governed admissions, policy.

Second, there were no differences in the quality of care provided to direct entry and regular SNF medicare patients, nor were there any patient outcome differences.

Third, the best estimate of the total net effect on medicare part A expenditures was a net saving of 0.1 percent of the medicare part A expenditures—$182,000—in Oregon and a net cost of 0.02 percent—$122,000—in Massachusetts.

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[1] Evaluation of the Three Day Hospital Stay Requirement for Medicare SNF Reimbursement. ABT Associates, Inc., Cambridge, Mass., Sept. 30, 1981. AAI Report No. 81-76, HCFA Contract No. 500-79-0051.

Fourth, the best estimate of the national effect of the direct entry option on medicare part A expenditures is that SNF expenditures in 1980 would have increased by $46 million and hospital expenditures would have decreased by $49 million.

The net change would have been a $3 million—0.014 percent—reduction in medicare part A expenditures. A reasonable set of bounds on this estimate for the net effect for medicare would be between a $28 million savings and a $13 million cost.

I would like to review briefly the evaluation methodology used in the expenditure analyses.

The original goal of the evaluation was to assess separately the effects of demonstration programs operating in two different States. In conducting this type of evaluation, a number of methodological issues have to be resolved. A typical approach is to look at the immediate and primary consequences of the demonstration and was adopted here.

The economic analyses gave primary consideration to two issues that have the most impact. Those were changes in hospital utilization and changes in SNF utilization.

Estimates regarding these factors define the order of magnitude of the ultimate cost or savings. Thus, these two issues, hospital utilization and nursing home utilization, became the primary focus.

Quantitative analyses of patient and facility level data were used to address medicare part A utilization and expenditure issues. The analyses considered the extent to which hospital days were avoided by use of the direct entry option, as well as the additional SNF days and expenditures involved.

We estimated that approximately 41 percent of the direct entry patients in Massachusetts and 67 percent in Oregon would have been hospitalized in the absence of the direct entry option.

The major cause for the differences between the Massachusetts and Oregon results involve the unusually high concentration of rehabilitation hospital/SNF's in Massachusetts and their disproportional involvement in the demonstration.

Massachusetts also experienced a low number of SNF admissions directly from the patient's home—a likely consequence of relatively low levels of program awareness and physician involvement in nursing home care in general in Massachusetts.

The national projections of medicare expenditure consequences of the waiver were directly based on the experience observed in the two States. As I indicated before, a range of estimates was prepared based on simulations. These simulations took into account the probability of hospitalization, the expected tradeoff between hospital and medicare SNF days, and average per diem medicare expenditures in 1980.

Our view of the most likely effect of a nationwide direct entry option is a national saving of about $3 million under conditions that were observed in the demonstration.

While there is potential for medicare savings by eliminating the prior hospital stay requirement, the ultimate effect is complicated and depends on a variety of additional factors. I will now review four of those.

First, a fundamental point of my remarks is that each of the two demonstrations led to different results. While I feel confident that

we have done a correct evaluation of the two demonstrations, a number of considerations make national projections very difficult.

I cannot absolutely say whether the ultimate effect of the waiver involves a cost or a savings to medicare. There are a number of factors that could increase or decrease the national estimates presented in the final report. These include other legislation that you are now considering.

The most critical issue is the extent to which the waiver diminishes days of care in hospitals, which are about four times as expensive as a day of care under SNF. The data used to estimate the number of avoided hospital stays were derived from discussions about the case histories of 276 randomly selected direct entry patients with the directors of nursing in 8 SNF's in Oregon and 10 in Massachusetts that were relatively high users of the direct entry option.

Our national projections are based on a combination of the results observed in both States. Factors exist, however, which could cause either greater savings or potentially substantial greater costs as a result of a direct entry option.

For example, increased physician awareness of the option or a change in reimbursement incentives could lead physicians to admit patients to SNF's rather than hospitals when appropriate. Conversely, less stringent interpretation or enforcement of the medicare SNF criteria could lead to a substantial increase in the number of medicare SNF stays without an offsetting decrease in hospital days.

The important point is that savings can only be realized if approximately 50 percent or more of the direct entry patients would have been hospitalized without the waiver.

Second, our national estimate did not reflect the additional costs which might accrue to medicare as a result of reductions in hospital days, lower overall occupancy rates, and consequently higher per diem costs.

Since empty beds are the source of potential cost savings of a direct entry option, it is important to consider the cost of an empty bed to medicare. Such consideration may reduce the savings of the program below the amount reported in the evaluation.

Our view was that the added cost could be ignored since the overall effect of the program on hospital occupancy would be quite small, and the medicare share of any average fixed costs would also be quite small.

Medicare only pays a portion of the fixed cost of an empty bed. The portion that medicare pays can be approximated by medicare's share of total hospital reimbursement. Other complications involve variations in financing methods between the States.

Medicare's financial burden for an empty bed will vary depending on medicare utilization, reimbursement practices of other payors, especially medicaid, the importance of fixed costs, and overall occupancy levels.

Third, given the attractiveness of the medicare SNF benefit to the nursing facilities, it is reasonable to ask, "Why did the facilities not transfer more patients than they did onto the medicare SNF benefit using the direct entry option?"

I believe that the major limiting factors are the stringency and enforcement of the level of care criteria. The level of care criteria were strictly enforced for the direct entry patients by the SNF staff, as well as the demonstration staff.

If interpretation or enforcement of level of care criteria is loosened under a national program that allowed direct SNF entry, SNF's presumably would act on their preference for medicare over medicaid reimbursement and increase the number of internal transfers.

Thus, if reductions in the funding of utilization review weaken enforcement of the level of care criteria, SNF utilization could increase beyond the level observed in the demonstrations. In addition, fiscally pressed medicaid programs may attempt to switch medicaid nursing home patients to medicare status.

Fourth, physicians are also likely to affect the cost and utilization of the direct entry option. There is evidence that most physicians have little incentive to admit patients directly into an SNF when a hospital admission is possible.

A hospital is generally a more convenient location for physicians to care for their patients. Moreover, medicare reimbursement for physicians hospital visits requires less paperwork than nursing home visits.

The tradeoff between nursing home and hospital stays among waiver patients is only part of the potential effect of the waiver program. It was not possible to quantify all the benefits available from the direct entry option, particularly the benefits that patients and families gained from a more appropriate treatment pattern or the management flexibility available to SNF's.

In summary, while elimination of the hospitalization requirement does have the potential for cost savings for medicare, these additional considerations lead to uncertainty about the ultimate national consequences.

The most important qualification that I wish to place on the study findings involve extensions beyond the experience of Massachusetts and Oregon to the Nation at large.

The future national long-term care environment is likely to differ considerably from that studied under the demonstrations. If the constraints on utilization in the demonstrations are eased, utilization of the direct entry option, as well as regular medicare SNF admissions, would increase. Thus, the waiver could cost substantial amounts of dollars.

I would like to make a brief transition to talk about one of the other issues that have been brought up today. In concluding this testimony, I would like to comment briefly on the broader issues of nursing home reimbursement policies, which I have considered also in studies for HCFA about medicare nursing home reimbursement policies. I think the general conclusions are relevant for medicare as well.

The general conclusion there that I reached was that appropriately designed prospective reimbursement systems can be developed to affect positively those dimensions of nursing home care that are central to policymaking. I discuss the various options in my book "Public Pricing of Nursing Homes" that is being published next month by Abt Books of Cambridge, Mass.

Such a prospective reimbursement system based on cost analyses would foster groupings of patients according to their functional limitations by paying for the costs of their care accordingly.[1]

This view originates from the reluctance of nursing home operators to admit the more disabled and costly patients that account for a very large percentage of patients backed up in hospitals awaiting nursing home placement.

If it is suitably designed, prospective reimbursement could reduce the costs of admission both to nursing home operators and to public agencies and lead to other desirable public goals.

Thank you for allowing me this opportunity today. I will be happy to answer any questions.

[The prepared statement and additional material follow:]

STATEMENT OF HOWARD BIRNBAUM, PH. D., DIRECTOR OF AGING AND PUBLIC PUBLIC PROGRAMS, ABT ASSOCIATES, INC.

Mr. Chairman, I am Howard Birnbaum, the Director of Aging and Public Programs at Abt Associates Inc., in Cambridge, Massachusetts. The major issue about which I am pleased to provide testimony involves the cost implications of the elimination of the prior hospital stay requirement for Medicare reimbursement of skilled nursing care. At the end of my remarks, I also will comment briefly on some of the broader issues involving nursing home reimbursement. However, I first would like to introduce these comments.

For the last seven years, I have been involved in evaluative studies and research for the Department of Health and Human Services (and its predecessor, the Department of Health, Education and Welfare), including several projects for the Health Care Financing Administration, HCFA. These studies have considered a variety of issues affecting both acute and long term care, as well as several associated income security programs. It is my involvement as Director of a recently completed study for HCFA on the prior hospital stay requirement that brings me here today.

You are well aware of the growing concerns about cost, utilization, and quality issues surrounding nursing home care which affect so many beneficiaries of the Medicaid and Medicare programs and their families. The problems include high and continually rising expenditures, inappropriate placements, and inadequate types of care. Although expenditures for skilled nursing care are less than two percent of the total Medicare budget, Medicare patients may enter the hospital and incur unnecessarily expensive hospital stays because of entry requirements for the Medicare Part A skilled nursing benefit. One possible policy response that has been under congressional consideration over the past decade is the elimination of the three day prior hospital stay requirement for Medicare reimbursement of care in skilled nursing facilities (SNFs).

In 1977, the Health Care Financing Administration established demonstration programs in Massachusetts and Oregon to investigate the consequences of eliminating the prior hospitalization requirement. In 1979, HCFA contracted with Abt Associates Inc. to conduct an independent evaluation of these direct entry SNF demonstrations.

SUMMARY OF RESULTS

The key results from the evaluation, completed in September 1981,[1] are:

1. Direct entry SNF patients accounted for approximately 10 percent of the covered Medicare SNF admissions to participating demonstration SNFs. The dominant constraints on direct entry utilization were the effective strictness and enforcement of the Medicare criteria governing admissions to SNF care.

2. There were no differences in the equality of care provided to direct entry and regular SNF Medicare patients. Nor were there any patient outcome differences.

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[1] See Birnbaum, Howard et al. "Why Do Nursing Home Cost Vary?" Medical Care. November 1981, Vol. 19, No. 11.

[2] "Evaluation of the Three Day Hospital Stay Requirement for Medicare SNF Reimbursement." Abt Associates Inc., Cambridge, Mass., Sept. 30, 1981. AAI Report No. 81-76, HCFA Contract No. 500-79-0051.

3. The best estimate of the total net effect on Medicare Part A expenditures was a net saving of 0.1 percent of Medicare Part A expenditures ($182,000) in Oregon and a net cost of 0.02 percent ($122,000) in Massachusetts.

4. The best estimate of the national effect of the direct entry option on Medicare Part A expenditures is that SNF expenditures in 1980 would have increased by $46 million and hospital expenditures would have decreased by $49 million. The net change would have been a $3 million (0.014 percent) reduction in Medicare Part A expenditures. A reasonable set of bounds on this estimate for the net effect for Medicare would be between a $28 million savings and a $13 million cost.

ESTIMATION ISSUES

I would like to review briefly the evaluation methodology used in the expenditure analyses.

The original goal of the evaluation was to assess, separately, the effects of demonstration programs operating in two different states. In conducting this type of evaluation, a number of methodological issues have to be resolved. A typical approach is look at the immediate and primary consequences of the demonstration and was adopted here.

The economic analyses gave primary consideration to two issues:

Estimates of the increased costs to Medicare due to an increase in Medicare SNF stays; and

Estimates of potential savings due to avoided hospital utilization. Estimates regarding these factors define the order of magnitude of the ultimate cost (or savings). Thus, these two issues (hospital utlilization and nursing home costs) became the primary focus of the evaluation.

Quantitative analyses of patient and facility level data were used to address Medicare Part A utilization and expenditure issues. The analyses considered the extent to which hospital days were avoided by use of the direct entry option as well as the additional SNF days and expenditures involved.

We estimated that approximately 41 percent of the direct entry patients in Massachusetts and 67 percent in Oregon would have been hospitalized in the absence of the direct entry option. The major cause for the differences between the Massachusetts and Oregon results involve the unusually high concentration of rehabilitation hospital/SNFs in Massachusetts and their disproportional involvement in the demonstration. Massachusetts also experienced a low number of SNF admissions directly from the patient's home—a likely consequence of relatively low levels of program awareness and physician involvement in nursing home care.

The national projections of Medicare expenditure consequences of the waiver were directly based on the experience observed in the two states. As I indicated before, a range of estimates was prepared based on simulations.These simulations took into account the probability of hospitalization, the expected tradeoff between hospital and Medicare SNF days, and average per diem Medicare expenditures in 1980. Our view of the most likely effect of a nationwide direct entry option is a national saving of about $3 million.

While there is potential for Medicare savings by eliminating the prior hospital stay requirement, the ultimate effect is complicated and depends on a variety of additional factors. I will now review four of the more important factors.

1. A fundamental point of my remarks is that each of the two demonstrations led to different results. While I feel confident that we have done a correct evaluation of the two demonstrations, a number of considerations make national projections very difficult. I cannot absolutely say whether the ultimate effect of the waiver involves a cost or a savings to Medicare. There are a number of factors that could increase of decrease the national estimates presented in the Final Report.

The most critical issue is the extent to which the waiver diminishes days of care in hospitals, which are about four times as costly as SNF days. The data used to estimate the number of avoided hospital stays were derived from discussions about the case histories of 276 randomly selected direct entry patients with the directors of nursing in eight SNF's in Oregon and ten in Massachusetts that were relatively high users of the direct entry option. Our national projections are based on a combination of the results observed in both states. Factors exist, however, which could cause either greater savings or potentially substantially greater costs as a result of a direct entry option. For example, increased physician awareness of the option or a change in reimbursement incentives could lead physicians to admit patients to SNF's rather than hospitals when appropriate. Conversely, less stringent interpretation or enforcement of the Medicare SNF criteria could lead to a substantial increase in the number of Medicare SNF stays without an offsetting decrease in hospi-

tal days. The important point is that savings can only be realized if approximately fifty percent or more of the direct entry patients would have been hospitalized without the waiver.

2. Our national estimate did not reflect the additional costs which might accrue to Medicare as a result of reductions in hospital days, lower overall occupancy rates, and consequently higher per diem costs. Since empty beds are the source of potential cost savings of a direct entry option, it is important to consider the cost of an empty bed to Medicare. Such considerations may reduce the savings of the program below the amount reported in the evaluation. Our view was that the added cost could be ignored since the overall effect of the program on hospital occupancy would be quite small, and the Medicare share of any average fixed costs would also be quite small.

Medicare only pays a portion of the fixed cost of an empty bed. The portion that Medicare pays can be approximated by Medicare's share of total hospital reimbursement. Other complications involve variations in financing methods between the states. Medicare's financial burden for an empty bed will vary depending on Medicare utilization, reimbursement practices of other payors, the importance of fixed costs, and overall occupancy levels.

3. Given the attractiveness of the Medicare SNF benefit to the nursing facilities, it is reasonable to ask, "why did the facilities not transfer more patients than they did onto the Medicare SNF benefit using the direct entry option?" I believe that the major limiting factors are the stringency and enforcement of the level of care criteria. The level of care criteria were strictly enforced for the direct entry patients by the SNF staff as well as the demonstration staff.

If interpretation or enforcement of level of care criteria is loosened under a national program that allowed direct SNF entry, SNF's presumably would act on their preference for Medicare over Medicaid reimbursement and increase the number of internal transfers. Thus, if reductions in the funding of utilization review weaken enforcement of the level of care criteria, SNF utilization could increase beyond the level observed in the demonstrations. In addition, fiscally pressed Medicaid programs may attempt to switch Medicaid nursing home patients to Medicare status.

4. Physicians are also likely to affect the cost and utilization of the direct entry option. There is evidence that most physcians have little incentive to admit patients directly into an SNF when a hospital admission is possible. A hospital generally is a more convenient location for physicians to care for their patients. Moreover, Medicare reimbursement for physicians hospital visits requires less paperwork than nursing home visits.

The tradeoff between nursing home and hospital stays among waiver patients is only part of the potential effect of the waiver program. It was not possible to quantify all the benefits available from the direct entry option, particularly the benefits that patients and families gained from a more appropriate treatment pattern or the management flexibility available to SNF's.

SUMMARY

In summary, while elimination of the hospitalization requirement does have the potential for cost savings for Medicare, these additional considerations lead to uncertainty about the ultimate national consequences. The most important qualification to the study findings involves extrapolations beyond the experience of Massachusetts and Oregon to the nation at large. The future national long term care environment is likely to differ considerably from that studied under the demonstrations. If the constraints on utilization in the demonstrations are eased, utilization of the direct entry option as well as regular Medicare SNF admisssions would increase.

In conluding this testimony, I would like to comment briefly on the broader issue of nursing home reimbursement policy. I have considered these issues in a study for HCFA (Contract No. 600-77-0068) about Medicaid nursing home reimbursement policy.[1] The general conclusions seem relevant for Medicare as well; appropriately designed prospective reimbursement systems can be developed to affect positively those dimensions of nursing home care that are central to policymaking. Such a prospective reimbursement system based on cost analyses[2] would foster grouping of patients according to their functional limitations, by paying for the costs of their care accordingly. This view originates from the reluctance of nursing home opera-

[1] Birnbaum, Howard, et al., "Public Pricing of Nursing Home Care," Abt Books, Cambridge, Mass., March 1982 (in press).

[2] See Birnbaum, et al., "Why Do Nursing Home Costs Vary," Medical Care, November 1981, Vol. 19, No. 11.

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tors to admit the more disabled and costly patients that account for a very large percent of patients backed up in hospitals awaiting nursing home placement. If it is suitably designed, prospective reimbursement could reduce the costs of administration both to nursing home operators and to public agencies and lead to other desirable public goals.

Thank you for allowing me the opportunity to participate in these discussions. I will be happy to answer any questions you may have at this time.

EXCERPTS FROM "PATHWAY TO SKILLED NURSING CARE: EXECUTIVE SUMMARY"

[The full document is in subcommittee file]

3.0 STUDY OVERVIEW

In 1977, the Health Care Financing Administration (HCFA) established demonstration programs in Massachusetts and Oregon to investigate the consequences of eliminating the three day prior hospitalization requirement. Under Medicare demonstration authority, of Section 222, P.L. 92-603, HCFA waived (i.e., eliminated) the prior hospitalization requirement as a precondition for reimbursement for Medicare SNF level of care in the demonstration facilities. This action allowed Medicare reimbursement following direct entry of patients into participating demonstration skilled nursing facilities. Demonstrations were conducted under separate contracts (encompassing slight design variations) by Blue Cross of Massachusetts and Blue Cross of Oregon. Approximately 30 Medicare certified SNFs in each state were involved initially. Abt Associates Inc. (AAI) and its subcontractor, Hebrew Rehabilitation Center for Aged (HRCA), entered in a contract with HCFA in 1979 to evaluate these demonstrations.

The evaluation strategy involved three components: case study analyses, utilization and expenditure analyses, and patient outcome and quality of care analyses. The objectives were to provide useful information about the demonstrations and to consider what might be expected under national implementation of a direct SNF entry option. Several broad sets of questions were addressed:

To what extent was the direct entry option utilized? How did the design and implementation of the demonstrations and the long term care environment affect direct entry utilization?

How were Medicare utilization and expenditures affected by the demonstrations and what would be the probable impact on Medicare expenditures of national implementation of a direct SNF entry option?

How were the quality of care and outcomes experienced by patients affected by the demonstrations?

A case study investigated the first questions through on-site interviews and documents review. Interviewees included physicians and staff of demonstration and non-demonstration skilled nursing facilities, Blue Cross of Massachusetts and Blue Cross of Oregon (the demonstration contractors), hospitals, state Medicaid offices, and health planning agencies. The qualitative assessment considered the environments of both states and the demonstrations designs and implementation procedures.

Quantitative analyses of patient and facility level data addressed Medicare Part A utilization and expenditure issues.[1] The analyses considered the extent to which hospital days were avoided by use of the direct entry option as well as the additional SNF days and expenditures involved. Also considered were effects of the demonstration on acutal per diem charges in SNFs and on Medicare reimbursement for hospital, SNFs and home health services provided to beneficiaries in the year following a direct entry SNF stay.

The patient outcome and quality of care analyses compared the types of care provided to SNF patients and the differences in the discharge disposition, or outcome, that they experienced. A "vulnerability index" was developed to adjust for case mix severity differences. These analyses were complemented by medical record reviews by physicians and nurse clinicians. These medical and nursing reviews considered the adequacy and appropriateness of the care provided direct entry and regular Medicare SNF patients, focusing particularly on patients who died.

Data for the evaluation analyses included: Medicare Cost Reports completed by the demonstration and comparison SNFs; supplemental program data collected by the demonstration contractors; patient bills from the Bill History Retrieval File maintained by HCFA on Medicare patients; medical record abstracts as well as com-

[1] Medicare part B physician and other use was not considered.

plete medical records of samples of patients collected for the evaluation; and other secondary data.

SUMMARY OF RESULTS

The results of these analyses can be summarized briefly:

Expenditures

Most likely, there are no expenditure consequences to Medicare of allowing patients to directly enter SNF's, given continuation of current Medicare SNF level of care criteria, fiscal intermediary review procedures, and physican reimbursement incentives.

The evaluation's best estimate of the effect of the direct entry option on Medicare Part A expenditures is that SNF expenditures in 1980 would have increased by $46 million and hospital expenditures would have decreased by $49 million. The net change would have been a $3 million (0.014 percent) reduction in Medicare Part A expenditures.

A reasonable range for the net effect for Medicare would be between a $28 million savings and a $13 million cost, between a savings of 0.14 and a cost of 0.05 percent to Part A Medicare expenditures.

The evaluation's best estimate of the total net effect on Medicare Part A expenditures was saving of 0.1 percent of Medicare Part A expenditures ($182,000) in Oregon and a net cost of 0.02 percent ($122,000) in Massachusetts.

Utilization

Direct entry SNF patients accounted for approximately 10 percent of the covered Medicare SNF admissions to participating demonstration SNF's in Oregon and Massachusetts.

Patient Outcome

There were no patient outcome differences among functionally similar patients adjusted for case mix differences; there were no differences in the percentages of functionally similar direct entry and regular Medicare SNF patients who died or who remained in a SNF following their Medicare stay.

Quality of Care

As determined by a case-by-case clinical review, there were no differences in the overall quality of care provided to direct entry and regular SNF Medicare patients.

Constraints

The dominant constraints on direct entry utilization were the effective strictness of the Medicare criteria and the lack of physician financial and professional incentives to practice geriatric medicine. If the strictness of implementation of the criteria is eased, Medicare SNF utilization and expenditures will increase for both direct entry and prior hospital stay patients. The evaluation is unable to determine how changes in the criteria will affect such a trend. If physician incentives are changed to encourage the practice of geriatric medicine, Medicare SNF utilization and expenditures may increase, but may be offset by decline in Medicare hospital use.

The following sections consider the three sets of analyses: the case study, the utilization and expenditure analyses, and the quality/outcome analyses. It is important to realize that the absence of a randomized experimental design limits confidence concerning what would have occurred to direct entry patients had they been hospitalized. The demonstrations involved only Medicare SNF patients. No data were available on patients who were similar to direct entry patients but who did not receive Medicare SNF care.[1] The methodology developed was based on the goal of minimizing the analytic bias introduced when non-eqivalent comparison groups are used. While the comparison procedures (discussed below) rarely yield results that are as conclusive as those from a randomized design, it is the considered opinion of the authors that the procedures achieved their intended goal: accurate conclusions.

Chairman JACOBS. Mr. Gradison?

Mr. GRADISON. What do you think we ought to do?

Mr. BIRNBAUM. I think you have to really appreciate that: The demonstrations were set in two States, that the evaluation consid-

[1]Fiscal intermediaries have data only on Medicare patients; there were insufficient evaluation resources to identify comparison patients who did not receive Medicare SNF care through other means.

ered those two States' experiences, and the constraints on utilization that were present in the two States—which basically have to do with the criteria that medicare and the fiscal intermediaries develop, and that they enforce—and that these criteria only start with the 3-day requirement. The formalization of the criteria go for pages in the volumes that HCFA and the intermediaries publish and that nursing homes administer.

If there is any relaxation for whatever reason, in those criteria in the future, under a variety of policies that are being considered now, then I would not stand by those estimates.

Our findings were developed in the context of those criteria and those demonstrations and they were projected on the basis of that situation. If the criteria or their interpretation change, then it is up to you to evaluate how those changing factors might in fact lead to increases in medicare SNF utilization.

Mr. ANTHONY. What did he say?

Mr. BIRNBAUM. I will say it again.

Chairman JACOBS. No, don't say that again.

Mr. GRADISON. I understand what you are saying. Let me approach this in a slightly different way.

Some of us are of the view that hospice care should be covered under medicare and that it would in all likelihood produce savings. I am not sure if that is correct or if it is not correct, but I see it as related to this issue.

It is interesting that the example used by our colleague from Oregon was a terminal cancer patient and somebody for whom hospice care might have been the appropriate service in that particular situation.

How do you see the development of the hospice alternative fitting into this picture and, in particular, if hospice care were reimbursable, would it have a bearing on this issue?

It occurs to me that if hospice care were widely available, many of the cases that are being called to our attention that have to go for 3 days to the hospital before they get in the nursing home would be cared for through service in a hospice, and the arguments for this change might be diminished.

Mr. BIRNBAUM. That would be an example of a different situation than was found in the demonstrations.

Mr. GRADISON. Yes.

Mr. BIRNBAUM. However, I would also point out that there were substantial numbers of patients who entered under the demonstration who had terminal illnesses, particularly cancer, and we did notice that situation was more likely for the demonstration patients than for our comparison patients.

Chairman JACOBS. Mr. Anthony?

Mr. ANTHONY. I can see we are not going to resolve the issue as to who is right and who is wrong on the cost estimates, but the administration's witnesses asked and solicited some helpful suggestions about developing a more rational and workable remibursement approach. Apparently that seems to be part of the problem, both in medicare and medicaid, from their testimony and also from your testimony. Both of you really hit on that.

What suggestions and advice could you offer the committee to offer them in trying to come up with a best accounting system for

prospective reimbursement? You indicate that you think it is a good idea also, in your conclusion, and that seems to be part and parcel of the overall problem. It seems like this may solve some of our internal problems that we have and internal conflict.

Do you have any specific suggestions that you could either give us today or submit in writing for the record later on?

Mr. BIRNBAUM. I would be happy to submit some in writing later on, but just briefly, what I would be willing to say today is that the general reimbursement system does not sufficiently take account of differences in the costs of treatment for different patients. If you would design a system that would take account of the fact of these differences, for example that some patients cost more than other patients, that that musn't in fact help eliminate some of the hospital backup, and achieve other public goals. Perhaps, there are patients in hospitals whose level of care would cost more than what a medicaid agency, for example, might wish to pay. Paying nursing homes more for their care would increase the incentive to admit them to nursing homes.

On the prospective reimbursement issue, you might establish these rates in advance and you might establish the rates in a manner that would be able to be compatible with explicitly stated public goals.

For example, you might want more nursing homes in rural areas, in which case you might allow medicaid or medicare to pay, i.e., have a higher rate for care in rural areas, in which case nursing homes would have more beds in rural areas.

Mr. ANTHONY. It sounds good to me.

Mr. BIRNBAUM. By explicitly considering those factors in advance and establishing that type of a system and rates in advance, nursing homes would know what they would get paid, in advance. They might be able to react in a way that would further public policy goals, if the incentives were structured early in the process.

Mr. ANTHONY. So what you are saying is that if we really do an excellent job of redefining the payment schedules, that we can really drive public policies in the health care field, that we can really moderate through policies what actually happens in the deliverability of good, adequate medical care?

Mr. BIRNBAUM. I would agree with that, and you can certainly make the approach of paying for public care more rational.

Mr. ANTHONY. And make it rational at the same time. I think that this would be instructive for the committee. So if you would submit for the record later on, if that is permissible, Mr. Chairman, and I do make that request.

Chairman JACOBS. Without objection, it will be included.

Mr. ANTHONY. Thank you very much.

[The information subsequently received follows:]

ABT ASSOCIATES, INC.,
Cambridge, Mass., February 9, 1982.

Hon. ANDY JACOBS,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN JACOBS: During my testimony of February 2, 1982 before the Subcommittee on Health of the Committee on Ways and Means, you requested that I submit suggestions on the topic of prospective reimbursement for nursing homes.

While my comments here are necessarily brief, I hope they will further your thinking.

They are based on my forthcoming book,"Public Pricing of Nursing Home Care" (Abt Books, Cambridge, Mass., March, 1982), which discusses Medicaid nursing home expenditure and reimbursement issues. The book analytically organizes ways of thinking about nursing home public policy and develops a rationale (as well as some nuts and bolts suggestions) for the workings of a prototype prospective reimbursement system. Much of the initial work for the book was conducted as part of a contract for the Health Care Financing Administration completed several years ago. While my comments specifically apply to Medicaid reimbursement policy, I believe they are readily transferable to Medicare nursing home policy as well.

The characteristics of a desirable reimbursement system for nursing home operating costs include the following: It should set reimbursement rates prospectively; it should be facility-based; it should screen individual facility costs; it should be administratively easy to operate; and it should use "good" data.

The prototype system outlined below has these characteristics. While the system is developed for operating cost reimbursement, most of the comments are directly applicable to reimbursement of capital costs.

The system is designed to achieve a limited and realistic set of objectives. It assumes that the majority of homes are operating at reasonable efficiency and that the rate setting agency should concentrate on "outliers"—the very high-cost and very low-quality homes. In this way, the rate setting agency can use its limited resources to maximize its leverage in efforts to achieve public policy goals. Once the most serious problems have been resolved in the initial years, the rate setting agency can then proceed, if it wishes, with a more comprehensive review.

The system should be prospective. That is, rates should be set in advance of the year in which they take effect. Prospective reimbursement has many advantages vis-a-vis retrospective cost reimbursement. In particular, prospective reimbursement, i.e., setting the rates in advance of the period for which they apply, puts the operator of a nursing home at risk. This situation gives the nursing home operator incentive to contain costs. In addition, prospective reimbursement gives the rate setting agency greater control over the specification of the types and amount of nursing home care for which it wishes to pay. Thus, the rate setting agency is not in a reactive situation whereby it has to pay for whatever the nursing homes have decided to provide. Finally, prospective reimbursement allows better planning on the part of nursing home operators, for they know the constraints under which they will have to operate. In sum, prospective reimbursement should create an environment wherein rational management decision making can take place.

For equity reasons, the rate should be facility-based (i.e., based on the costs of the individual facility). This requirement need not mean that the rate equal the costs of a particular facility, nor that only the costs in the previous year should be considered. For legitimate reasons, different facilities may have different costs. Thus, equity considerations imply that these legitimate differences must be recognized. For example, facilities that serve a more costly patient mix could (but need not necessarily) receive higher levels of reimbursement. Decisions about what should and should not be reimbursed would be made explicitly by the rate setting agency.

Because some of these facility and patient differences can never be fully captured by the data, a rate developed strictly on the basis of a cost equation formula will inevitably ignore some of the differences and create inequities. The result could be excessive litigation, as was the case in the state of Washington, which tried to use a formula system based on cost function analysis. In addition, a strict formula-based system creates incentives for homes to misrepresent patient, input, outcome, and cost data in a way that maximizes the reimbursement rate. The prototype method substitutes cost screens based on cost function analysis with modifications made by the rate-setting agency to set the rate. Examples of the results of cost analyses are presented in my article on "Why Do Nursing Home Costs Vary?" in November, 1981, Medical Care. Such a procedure allows rate setters to maximize the policy effectiveness of the incentives. Public Pricing of Nursing Home Care reviews this approach in detail, including issues involved in the day-to-day operation and process of the rate setting agency.

The system should be relatively easy to implement, so that administrative costs and time of both the agency and nursing homes are minimized. To improve the administrative efficiency of the rate agency, the system should minimize the need for retrospective adjustments. Rate setters should concentrate on setting next year's rate rather than resolving previous problems. Finally, the rate-setting authority would include both rate setters and facility inspectors under a single organization. Such an umbrella administration (which is very different from the typical situation)

would integrate the information collection process and eliminate problems of coordinating facility input, output, and quality data with cost data.

A final desirable trait of the prototype reimbursement system is that it makes use of accurate data on relevant nursing home and patient characteristics. A reimbursement rate based on incomplete or inaccurate data means that the regulatory system is less efficient and less equitable. If the necessary data are accurate and fully utilized, then the accuracy of the screen will be improved to allow those homes having excessive costs or low quality to be identified and the rates to be set at the proper levels. Because the system requires large amounts of accurate data, areas without such data could face major data collection efforts. There is little possibility of improving upon existing nursing home reimbursement practices without improved data.

I would be happy to elaborate on these and other issues further if you desire more information. I hope that my testimony and these comments are useful. I would be delighted to assist you further regarding nursing home and other public policies regarding the Aged.

Sincerely,

HOWARD BIRNBAUM, PH. D.,
Director, Aging and Public Programs.

Chairman JACOBS. Mr. Birnbaum, what fee did your company receive from the Government for this study?

Mr. BIRNBAUM. The cost of the evaluation paid to Abt Associates by the Government was $335,000. That was just for the evaluation. The demonstrations were funded by HCFA directly to Blue Cross, and were run by the Blue Cross organizations in Massachusetts and in Oregon. I don't know what amount they paid for that.

Chairman JACOBS. Where did I see the figure of $700,000? Is that something else? Oh, a Congressman said $750,000.

Mr. BIRNBAUM. That included the costs of the demonstrations.

Chairman JACOBS. We always deal in big numbers; just like those television quiz programs. For $350,000, knowing what you know now, if you were sitting here, yea or nay on direct entry?

Mr. BIRNBAUM. I don't know enough about the changes that will accompany this and other changes in medicare legislation.

Chairman JACOBS. Ceterus paribus, which I believe means all things remaining the same, yea or nay?

Mr. BIRNBAUM. Can I not vote?

Chairman JACOBS. It depends on what you think $350,000 will buy us.

Mr. BIRNBAUM. Ceterus paribus, the study said that my best estimate was $3 million of savings. If that were my criteria and I believe the future environment would be similar to that found in the demonstrations, then ceterus paribus I would go with my $3 million in savings.

Chairman JACOBS. Good enough. Thank you very much for your testimony.

The next scheduled witnesses represent the American Health Care Association, Samuel Gunnerson and Marc Levin.

Come forward, submit your statements for the record—summarize or read them for the record, whichever you wish. Mr. Gunnerson, welcome to Washington. I don't quite know how you got out of Indianapolis.

STATEMENT OF SAMUEL GUNNERSON, GUNNERSON ASSOCIATES, INDIANAPOLIS, IND., ACCOMPANIED BY MARC B. LEVIN, DIRECTOR, OFFICE OF HEALTH PROGRAM ADMINISTRATION AND FINANCING, AMERICAN HEALTH CARE ASSOCIATION

Mr. GUNNERSON. Thank you. Mr. Chairman and members of the committee: The American Health Care Association, the Nation's largest association of long-term care facilities with nearly 8,000 member providers, is pleased to present our recommendations for cost-effective changes in the reimbursement and coverage of skilled nursing facilities under medicare.

I am Samuel Gunnerson, past chairman of the AHCA payment for services committee, and with me is Marc Levin, director of health program administration and financing for AHCA. I will provide a brief summary of our comments and request that our full testimony be included in the record.

Chairman JACOBS. Without objection.

Mr. GUNNERSON. The first topic I would like to address is a reform of medicare reimbursement policies. AHCA recommends that the medicare program can achieve significant savings and enable beneficiaries to receive the appropriate services in the least costly setting by implementing a prospective reimbursement system for skilled nursing facilities [SNF]. The prospective payment system must include incentives for efficiency and cost containment.

There is a serious problem with the lack of participation by long-term care facilities in the medicare program. As a result, many medicare beneficiaries in need of SNF care are not able to receive the appropriate care and are "backed-up" in expensive hospitals longer than necessary awaiting SNF placement.

Medicare's inappropriate payment system is a major reason for the lack of participation by SNF's in medicare. We believe that if medicare adopted a prospective payment system, more SNF's would participate, beneficiaires would be able to receive needed SNF care more promptly, and the medicare program would achieve long-run savings by paying for SNF care in lieu of hospital care and by providing incentives for efficiency and cost containment.

It is estimated that at any given time there are 19,000 medicare beneficiaries "backed up" waiting for a SNF bed and medicare dollars are being wasted. A national survey undertaken in 1980 by the American Association of Professional Standards Review Organizations reflected that medicare was paying for more than 6 million days of hospital care per year for patients for whom a bed in an SNF could not be found.

Before addressing the prospective payment system it is first helpful to review some relevant facts and developments concerning medicare and nursing homes. Nursing home services are a small component of medicare. Less than 2 percent of medicare cost is for nursing homes. Similarly, medicare accounts for only a very small proportion, less than 2 percent, of total payments for nursing homes.

The nursing home component of medicare has been steadily decreasing both in terms of covered days—per 1,000 enrollees—and in the growth in nursing home expenditures as compared to hospital

expenditures. Nursing home days per 1,000 enrollees dropped over 17 percent between 1977 and 1979.

Approximately one-third of the SNF's choose not to participate in the medicare program, and many who are certified for medicare choose not to take medicare beneficiaries if other patients are available. Congress was concerned about the inadequate access of medicare patients to SNF's and because of this subcommittee's initiative the Omnibus Reconciliation Act of 1980 instructed HCFA to study the causes and the extent to which laws and regulations discourage medicare participation.

In response, HCFA funded a study by the Urban Institute, which was recently completed. The study supports the finding that Medicare patients do not have adequate access to SNF beds because of providers' reluctance to participate in the program and/or admit medicare patients.

The eroding nursing home benefit under medicare must be restored from the perspective of both the beneficiary and the program. Medicare beneficiaries are entitled to SNF care and believe they will receive this care. However, because the program does not provide sufficient access to nursing homes, many beneficiaries are forced to go without the care they need or are forced to remain in hospitals.

When beneficiaries remain backed up in hospitals, they are not receiving the appropriate care needed. A hospital is not prepared to provide many of the services such as activity services and group dining services that are appropriate for patients in need of SNF care. Thus a patient is maintained in an inappropriate, more confined setting than would be best for the patient's needs.

The use of a prospective payment system for nursing homes is not a new, untried idea. The virtues of prospective reimbursement are known. Over two-thirds of the State medicaid programs have successfully employed prospective payment systems for nursing homes for several years. The experience of States is that prospective reimbursement has proven to reduce the growth in costs.

Prospective payment rates for nursing homes will also instill market forces into the system and enable the program and Congress to gain valuable experience before applying such a system to the more costly hospital component of the program. Providers would not have to deal with retroactive recoveries but would inherit the risks and the returns of receiving a prospective rate.

Congress and the administration have continually indicated that medicare should adopt a prospective payment system. Additionally, the White House Conference on Aging recently recommended that a prospective reimbursement system be used under medicare. The need, advantages, and support for prospective payment rate are clearly evident.

The payment system adopted must result in prospective rates that contain incentives for efficiency, provides for the adequate reimbursement of property costs, and allows owners the opportunity to make a fair return. In any viable business an opportunity for adequate return on investment and fair recognition of property costs are needed for renovation, upkeep, and future development.

Additionally, the system should reduce administration redtape, reduce unnecessary paperwork, and be easy to administer in con-

trast to the current system which is complicated and burdensome for the provider and the program.

There are obviously various ways of consructing a prospective payment system for medicare. We will present two possible approaches, both of whch incorporate the fundamentals outlined above. The first is a formula approach whereby a ceiling or target rate is established. Based on a facility's costs, a projected prospective rate is calculated.

If the projected rate is less than the target/ceiling, a profit factor would be added to the facility's rate as a reward and incentive for operating efficiently. The sum would result in the prospective rate. The rates in this system would thus be established based on each facility's costs.

The second is a fee schedule or rate chart approach. Under this approach medicare would establish a rate to be paid for all SNF's in a geographical area. The rate to be paid would be made public and all facilities in that area would receive that particular prospective rate for medicare patients and would not need to submit a cost report. In composing the prospective rate for a geographical area, however, the program would need to build in the fundamentals previously identified.

In summary, we believe that Congress needs to act now to adopt a prospective payment system for nursing homes under medicare and that the program cannot afford to continually delay in this area.

I would like to offer these additional recommendations on other aspects of the program. I will vote yes to eliminate the maximum 3-day prior hospitalization requirement as proposed by Mr. Wyden.

Eliminate inconsistencies in the "spell of illness" definition so that a spell ends when a beneficiary is neither under medicare inpatient nor SNF coverage followed by the requisite time period.

Allow physician assistants and nurse practitioners, acting under the general supervision of a physician, to conduct visits and recertify care plans of SNF care.

The SNF benefits were intended by Congress to be a substitute for more costly hospital care in the course of treating an acute illness. However, the result of limited nursing home services and inappropriate policies has been to reduce the elderly's access to covered care and to escalate medicare expenditures for unnecessary and costly hospital stays. Medicare is penny-wise, dollar-foolish in the coverage and accessibility of posthospital extended care services.

Thank you for the opportunity to testify. We are pleased that the subcommittee has addressed medicare skilled nursing issues so early in the year. We are prepared to work with you so that this year the medicare skilled nursing benefits can finally become what the beneficiaries need and think they have available.

[Booklet "Medicare and the Nursing Home Patient" available in the subcommittee files.]

[The prepared statement follows:]

STATEMENT OF SAMUEL GUNNERSON, FOR THE AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and members of the subcommittee, the American Health Care Association, the nation's largest association of long term care facilities with nearly 8000 member providers, is pleased to present our recommendation's for cost-effective changes in the reimbursement and coverage of skilled nursing facilities under Medicare. I am Samuel Gunnerson, past chairman of the AHCA Payment for Services Committee, and with me is Marc B. Levin, Director of Health Program Administration and Financing for AHCA.

PROSPECTIVE PAYMENT SYSTEM FOR SNF'S

The first topic I would like to address is a reform of Medicare reimbursement policies. AHCA recommends that the Medicare program can achieve significant savings and enable beneficiaries to receive the appropriate services in the least costly setting by implementing a prospective reimbursement system for skilled nursing facilities (SNF). The prospective payment system must include incentives for efficiency and cost containment.

There is a serious problem with the lack of participation by long term care facilities in the Medicare program. As a result, many Medicare beneficiaries in need of SNF care are not able to receive the appropriate care and are "backed-up" in expensive hospitals longer than necessary awaiting SNF placement. Medicare's inappropriate payment system is a major reason for the lack of participation by SNFs in Medicare. If Medicare adopted a prospective payment system more SNFs would participate, beneficiaries would be able to receive needed SNF care more promptly, and the Medicare program would achieve long run savings by paying for SNF care in lieu of hospital care and by providing incentives for efficiency and cost containment. An independent study funded by AHCA, "Medicare and the Nursing Home Patient: The High Cost of the Shortage of Medicare-Certified Skilled Nursing Home Beds", which elaborates many of the points we will raise is attached as an appendix to this testimony.

At any given time there are 19,000 Medicare beneficiaries "backed-up" waiting for a SNF bed and Medicare dollars are being wasted. A national survey undertaken in 1980 by the American Association of Professional Standards Review Organizations reflected that Medicare was paying for more than 6 million days of hospital care per year for patients for when a bed in a SNF could not be found. A recent study by the Urban Institute confirms these estimates. The study found that because of the limited access to nursing home beds, Medicare and Medicaid pay for an estimated 1 to 8 million hospital days per year for patients unable to find a nursing home bed.

Last year the House Select Committee on Aging reported that "cutbacks in the Medicare nursing home program have resulted in keeping thousands of older Americans in hospitals longer than necessary at four times the average daily cost." The Committee estimated that "retaining patients in hospitals longer than necessary is costing Medicare and the nation $1.5 billion a year."

Before addressing the prospective payment system it is first helpful to review some relevant facts and developments concerning Medicare and nursing homes. Nursing home services are a small component of Medicare. Less than two percent of Medicare cost is for nursing homes. Similarly, Medicare accounts for only a very small proportion, approximately two percent, of total payments for nursing homes. National nursing home costs are primarily paid by Medicaid (50 percent) and personal resources/family support (42 percent).

The nursing home component of Medicare has been steadily decreasing both in terms of covered days (per thousand enrollees) and in the growth in nursing home expenditures as compared to hospital expenditures. Nursing home days per thousand enrollees dropped over 17 percent between 1977 and 1979.

Approximately one-third of the SNFs choose not to participate in the Medicare program, and many who are certified for Medicare choose not to take Medicare beneficiaries if other patients are available. Congress was concerned about the inadequate access of Medicare patients to SNFs and because of this Subcommittee's initiative the Omnibus Reconciliation Act of 1980 instructed HCFA to study the causes and the extent to which laws and regulations discourage Medicare participation. In response, HCFA funded a study by the Urban Institute which was recently completed—Medicare and Medicaid Patients' Access to Skilled Nursing Facilities. The HCFA report was due in December 1981.

The Urban Institute study supports the finding that Medicare patients do not have adequate access to SNF beds because of providers' reluctance to participate in the program and/or admit Medicare patients.

Some of the findings and conclusions of the study are:

Medicare and Medicaid patients have problems obtaining the nursing home care to which they are entitled.

Because of limited access to beds, Medicare and Medicaid pay for an estimated one to eight million hospital days per year, for patients unable to find a nursing home bed.

One-third of the skilled nursing facilities participating in Medicaid do not participate in Medicare.

Participating homes may avoid billing Medicare—instead billing patients directly or billing Medicaid—where Medicare coverage is uncertain or difficult to acquire.

Greater uniformity in administration of Medicare's nursing home benefit would assure Medicare beneficiaries more equal access to the coverage the law provides.

If Medicare used a prospective payment system, more homes would participate in Medicare, increasing the number of beds available to Medicare patients.

The eroding nursing home benefit under Medicare must be restored from the perspective of both the beneficiary and the program. Medicare beneficiaries are entitled to SNF care and believe they will receive this care. However, because the program does not provide sufficient access to nursing homes many beneficiaries are forced to go without the care they need or are forced to remain in hospitals. When beneficiaries remain backed up in hospitals they are not receiving the appropriate care needed. A hospital does not provide many of the services such as activity services and group dining services that are appropriate for patients in need of SNF care. Thus, a patient is maintained in an inappropirate more confined setting than would be best for the patient's needs. It should be noted that an increase in Medicare participation of nursing homes is not an expansion of benefits but rather an increase in beneficiary's access to existing benefits.

From the program's perspective, increasing beneficiary access to nursing homes will reduce the back-up of patients in hospitals and enable the program to pay for less costly SNF care. Although Congress recently enacted provisions which reduce payments to some hospitals for patients in need of SNF care, the mechanics and nature of the Medicare payment system for hospitals are such that significant savings will not result from that approach. This is confirmed by the Urban Institute study.

The SNF benefits were intended by Congress to be a substitute for more costly hospital care in the course of treating an acute illness. However, the result of limited nursing home services and inappropriate policies has been to reduce the elderly's access to covered care and to escalate Medicare expenditures for unnecessary and costly hospital stays. Medicare is "penny wise, dollar foolish" in the coverage and accessibility of post-hospital extended care services.

The major reason for the low participation is the Medicare reimbursement system. The current retrospective reimbursement system is unsatisfactory because it is inflationary, contains no incentives for efficiency, and no financial incentives for SNFs to participate. A reimbursement method that allows nursing homes simply to pass costs through the system without providing them with any real incentive to cut those costs must be considered inflationary. Much of the dramatic increase in costs for all health care services over the last ten years can be attributed to the use of cost reimbursement. When costs are retrospectively determined, nursing homes cannot determine at any moment what they are being reimbursed and hence link the level of care being provided with the reimbursement they will receive. Under such conditions, setting budgets and monitoring performance is difficult. A nursing home that contains costs and increases efficiency is penalized by having its reimbursement level reduced by the size of the saving. Cost reductions only reduce income.

The use of a prospective payment system for nursing homes is not a new, untried idea. The virtues of prospective reimbursement are known. Over two-thirds of the State Medicaid programs have successfully employed prospective payment systems for nursing homes for several years. The experience of states is that prospective reimbursement has proven to reduce the growth in costs because of provider advantage to more efficient performance. One study (Robert Buchanan; California State College) found that between 1976 and 1977, Medicaid SNF payments increased 29 percent less in states that had prospective rate setting programs.

Prospective payment rates will instill market forces into the system. Providers would not have to deal with retroactive recoveries but would inherit the risks and the returns of receiving a prospective rate. Once the facility's rate is determined the provider would provide services for that rate and would incur a loss if its costs were too high or would receive a profit if its costs could be kept lower than the rate.

Congress and the Administration have continually indicated that Medicare should adopt a prospective payment system. Additionally, the White House Conference on Aging recently recommended that a prospective reimbursement system be used under Medicare. The need, advantages, and support for prospective payment rates are clearly evident.

Applying a Medicare prospective payment mechanism to nursing homes prior to its application to hospitals would provide valuable experience to the program and Congress. Since the expenditures for the SNF component under Medicare are minimal compared to the hospital component, the financial risk to Medicare and skilled nursing providers in making a change is much less than for hospitals.

The next aspect we will address are some of the specifics of establishing a prospective payment system. The system must result in prospective rates that contain incentives for efficiency, provides for the adequate reimbursement of property costs, and allows owners the opportunity to make a fair return. Additionally, the system should reduce administrative "red tape," reduce unnecessary paperwork, and be easy to administer in contrast to the current system which is complicated and burdensome for the provider and the program.

Unlike the existing payment system, the prospective methodology must provide incentives for efficient operation in order to restrain the growth in costs. Efficiency would be encouraged through the use of pre-deternined rates. Providers able to keep their costs below the prospective rate or a target level would retain the savings for operating efficiently. Conversely, providers unable to keep their costs below the prospective rate should be responsible for incuring the loss. Additionally, as in any viable business an opportunity for adequate return on investment and fair recognition of property costs are needed for renovation, upkeep, and future development. Such fundamentals must be part of the Medicare payment system.

There are obviously various ways of constructing a prospective payment system for Medicare. We will present two possible approaches, both of which incorporate the fundamentals outlined above. The first is a formula approach whereby a ceiling or target rate is established. Based on a facility's costs a projected prospective rate is calculated. If the projected rate is less than the target/ceiling a profit factor would be added to the facility's rate as a reward and incentive for operating efficiently. The sume would result in the prospective rate. The rates in this system would thus be established based on each facility's costs.

The second is a fee schedule or rate chart approach. Under this approach Medicare would establish a rate to be paid for all SNFs in a geographical area. The rate to be paid would be made public and all facilities in that area would receive that particular prospective rate for Medicare patients. Facilities would not have to submit cost reports since the rate would be established independently of their particular costs. In composing the prospective rate for a geographical area, however, the program would need to build in the fundamentals of an opportunity for profit, fair recognition of property costs, and incentives for efficiency.

In summary, we believe that Congress needs to act now to adopt a prospective system for nursing homes under Medicare and that the program cannot afford to continually delay in this area. Such a system would increase participation by SNFs in Medicare, reduce the back-up of Medicare patients in hospitals, and reduce the growth of provider costs. Also, Medicare patients would no longer be discriminated against and would be able to receive the medically appropriate level of care in the least costly setting. Moreover, the use of prospective payments for nursing homes would enable the program to instill market forces into the payment system and gain valuable experience before applying such a system to the more costly hospital component of the program.

PRIOR HOSPITALIZATION

AHCA recommends the elimination of the minimum three day prior hospitalization requirements for SNF coverage as proposed in H.R. 4227 by Mr. Wyden and 41 cosponsors. The subcommittee took the leadership two years in eliminating the same counterproductive barrier to home health services, and should now follow-through with regard to extended care services. This change would provide Medicare beneficiaries with greater flexibility in their long term care coverage and result in lowering overall costs for both the patient and the Medicare program.

The most thorough, objective examination to date on this issue is the recently completed three-year HCFA demonstration projects in Oregon and Massachusetts and evaluation report by Abt Associates, Inc. The record shows likely Medicare savings would result from elimination of the requirement. We are disappointed that HCFA staff is unrelently in this insistence on the requirement, largely raising com-

plaints about the methodology of their own approved, now finished study and digging up 10 year hospital utization data. We know of no other public or private health plan which finds in such a requirement.

The current restriction is arbitrary, unnecessary and burdensome. There are many individuals who are otherwise eligible for skilled nursing care but because they are not acutely ill or do not require the complete and costly diagnostic and therapeutic resources available in hospitals cannot be admitted to a SNF with Medicare eligibility. There are also those who "game" the program by arranging for unnecessary (and costly) hospital stays in order to become eligible for SNF Medicare benefits. In addition, there are individuals receiving hospital care who would benefit as much from SNF care but who are not transferred to an SNF because of the paperwork (e.g., transfer of medical records, treatment plan) and the lack of any financial incentives or disincentives (e.g., no cost sharing is required after the hospital deductible until the 61st day).

The removal of the requirement would recognize the legitimate needs of individuals who require only skilled nursing services. Because the cost of Medicare services in an SNF is far less than in a hospital, the potential for medicare cost savings are obvious. Direct admission to an SNF would also mean that an individual otherwise qualified for Medicare benefits would not be faced with a choice between spending substantial personal resources to pay for SNF care or seeking unnecessary hospital care.

To the extent that the three-day requirement was intended by Congress to assure that a medical evaluation of the individual's condition demonstrates the need for skilled nursing services, we believe that controls such as physician certification and concurrent utilization review can provide the necessary assurance and satisfactorily replace the expensive hospital "gatekeepers."

SKILLED NURSING CARE

One of the major ways for Medicare to provide more economical and appropriate services is to allow SNF coverage for a broader range of patient needs. Medicare narrowly limits coverage to patients who require daily nursing care or have rehabilitation potential. A difficult and common situation for nursing home administrators is to have to explain to Medicare patients and their families the realities of the restricted extended care coverage. The Medicare program has not adapted its SNF coverage for the past nine years to take better advantage of the services which can be provided in today's long term health care facilities. In particular, AHCA Recommends that Medicare allow SNF coverage for care of the terminally ill.

We are aware of interest in the bill, H.R. 5180 introduced by Mr. Panetta, to provide Medicare coverage for hospice care. It is understood that the Subcommittee does not wish to focus on the issues raised by that legislation at this hearing and so we will reserve specific comment until later.

We do urge, however, consideration be given to the immediate opportunity to make substantial progress by making this cost-effective expansion in SNF coverage. Long term health care facilities do have, unfortunately, much experience in care of the dying. But Medicare does not recognize this as a sufficient patient need for SNF coverage. Yet SNFs are often a more appropriate setting and certainly much less costly alternative to hospital in which most of the Medicare terminal care is currently provided.

Terminally ill Medicare patients, the Hospital Insurance Trust Fund, and skilled nursing facilities could receive immediate benefit from the utilization of existing providers, even with the current 100 day limit and patient co-insurance, until the major complex issues about hospice cost controls, provider requirements, and service packages are resolved.

Another cost-effective opportunity utilizing long term health care facilities AHCA recommends is Mr. Duncan's bill, H.R. 211, for demonstration projects for Medicare patients receiving chemotherapy or radiation therapy to stay in non-hospital settings. Skilled nursing and intermediate care facilities would be well suited to handle the nursing and convalescent needs of such cancer patients.

A recent Department of Health and Human Services report by the office of Inspector General brought to light the problem of possibly large numbers of patients receiving chronic long term care in acute care hospitals at acute care costs. This population of chronically ill hospitalized patients is in addition to those patients ready to be discharged but waiting for skilled nursing facility placement. Rather, the group in question represents chronically ill older people perhaps alcoholics or other substance abusers, who, because of lack of ongoing medical management or adequate shelter, require numerous hospital admissions and lengthy stays for acute

episodes of chronic conditions. These chronically ill patients pose a significant expense to the Medicare program. Also in this group are the long term hospitalized patients, those who cannot be placed in nursing homes because of their numerous care needs but at the same time, are not truly in need of hospital services.

AHCA recommends that Congress direct the Department of Health and Human Services to do the following regarding chronically ill hospitalized patient:

Evaluate to what extent this group of patients is served under the Medicare program.

Consider a new system of reimbursement for those patients if the number seems significant enough to warrant a special program. This could include a lower than customary hospital rate or a higher then customary SNF rate.

Target services to chronically ill patients at risk of numerous acute care episodes. Community based and long term care facility services should consider these people to be priority cases. Traditional utilization criteria systems may have to be disregarded when normally uncovered maintenance care could forestall acute episodes. This viewing patients in terms of overall and risk needs would be not only cost effective, but certainly more humanitarian.

SPELL OF ILLNESS

AHCA recommends eliminating inconsistencies in the "spell of illness" definition so that a "spell" ends when a beneficiary is neither under Medicare inpatient hospital nor SNF coverage followed by the requisite time period. In general, the Medicare program limits the duration of covered services to the period between the beginning and ending of a "spell of illness." Under present law, a Medicare beneficiary must remain for 60 consecutive days out of a hospital or SNF in order to renew his Medicare eligibility for these benefits.

The proposed amendment would eliminate inconsistencies in the SNF criteria used to start and end a spell of illness. For purposes of starting a spell of illness and receiving benefits, the beneficiary must be in a facility which is licensed as an SNF, certified under Medicare as a SNF, and meets all of the program's requirements for participation as a SNF. However, for purposes of "classifying" facilities to determine if a patient is no longer in a "skilled nursing facility" and thus ending a spell of illness, the program uses a very broad definition of a skilled nursing facility which encompasses many facilities not certified as a SNF and not eligible to participate in the program as a SNF.

Under Medicare's policies, many intermediate care facilities are classified as providing skilled nursing care, only for purposes of ending a spell of illness. As a result of this inconsistent policy, a beneficiary placed in a facility licensed as an ICF but which is classified by Medicare as providing skilled nursing care for spell of illness purposes will not receive Medicare coverage when he needs to go back to a hospital for SNF. Coverage would not be received because the spell of illness had been deemed not to have ended.

Medicare's policies for determining when a spell of illness ends are clearly inconsistent and stacked against beneficiaries. Although their position is tenuous, the program has continually argued that their policies reflect the statute and can not be changed without a legislative clarification.

A similar HCFA policy adversely affects beneficiary coverage for durable medical equipment (e.g., oxygen therapy, alternating pressure matresses, and pacemaker monitors). The durable medical equipment is available to beneficiaries at home or an institution, other than those meeting the broad definition of SNF. AHCA recommends the Part B durable medical equipment coverage be available to a beneficiary who is neither under Medicare inpatient hospital nor SNF coverage.

PHYSICIAN SERVICES

Federally financed demonstrations have proven that geriatric nurse practitoners and physician assistants can perform cost effective and high quality services which traditionally have been provided by physicians.

These physician extenders, however, are rarely used in long term care facilities to perform these "physician services." The cause of underutilization of these new health professionals is twofold: (1) despite the services that may be performed by physician assistants and geriatric nurse practitioners, physicians are required to perform the same services under Medicare law and regulations. (2) The Medicare program does not permit reimbursement for nurse practitioner and physician assistant services.

The Medicare law requires each patient to be under the supervision of a physician. Federal rules interpret this provision as physician visits at least every thirty

or sixty days. The Health Care Financing Administration references Section 1861(r) of the Social Security Act in defining a physician as a doctor of medicine or osteopathy and therefore could not permit a nurse practitioner or physician assistant to perform the physician service of routine visits. AHCA recommends that physician assistants and nurse practitioners, acting under the general supervision of a physician, be allowed to conduct visits and recertify care plans of SNF patients. This modification would be cost-effective and improve the medical care of patients. Physician extenders have proven utility for monitoring care, providing routine medical services, and appropriately involving the supervisory physician if major medical problems develop.

UTILIZATION REVIEW

Utilization review, the process designed to assure that patients receive the appropriate amount and level of care, AHCA recommends be revised. The seemingly straightforward provisions 1861(j)(8) and (k) cause paperwork, administration and professional burdens that we believe cannot be justified. Some of the problems include:

One hundred percent review, review of all patients, leaves no room for a flexible utilization review program. While this may be only a minor problem with a small number of skilled nursing facility Medicare patients, the concept is adopted by Medicaid where it constitutes an impractical demand.

Review by committee or group of physicians has proven to be an unaffordable and unnecessary requirement. Experience with the Professional Standards Review Organization (PSRO) program demonstrated that nurse and other reviewers can adequately determine the need for services. We recommend that 1861(k)(2), the requirement that utilization review be only by physician committee, be deleted.

A problem exists when a state receives a Medicaid waiver by developing an effective alternate utilization review program, but the Medicare program retains the utilization review committee structure. This necessitates the imposition of two different review programs in the same facility. We suggest that the Secretary be given flexibility and incentive to impose the most cost effective, uniform utilization review procedure for each provider, no matter what federal program is involved.

There are two tax issues related to long term care we wish to discuss briefly. We address our remarks to you as members of the full Committee as we realize these tax issues are beyond the Subcommittee's jurisdiction.

INDUSTRIAL DEVELOPMENT BONDS

AHCA is deeply concerned over recent proposals to eliminate Industrial Development Bonds (IDB) and other forms of tax-exempt bonds. AHCA recommends that Congress retain the use of tax-exempt IDBs for health care institutions such as nursing homes.

Industrial Development Bonds are extremely important to nursing home providers and the millions of elderly, chronically ill, and convalescent Americans who need long term health care. The use of IDBs by our members has grown in recent years. The demand for this form of financing will dramatically increase in the coming years and the importance IDBs will play in the availability of needed health care services can not be overlooked.

There is presently a shortage of nursing home beds. Worsening the current situation is that the demographics of the aging population indicate that thousands of new beds will be needed in this decade to continue to provide services to elderly individuals in need of care. The capital demand to construct these needed beds will be enormous and IDBs are a critical source of the capital. Without Industrial Development Bonds, the potential exists for a severe shortage of capital for developing the necessary nursing home beds and services because the financial community will not provide sufficient capital. Thus, eliminating IDBs may be equivalent to halting desperately needed expansion in the long term health care area.

Another consideration is that the Federal Medicaid and Medicare programs have significant expenditures for nursing home care provided to covered individuals. To the extent that the cost of financing long term care facilities increases, because IDBs are no longer available, the costs to the Medicaid and Medicare programs of purchasing these services will also increase. Therefore, the potential exists that not only will needed long term care services not be available because of inadequate growth in the industry, but also the cost of services to the Medicaid and Medicare programs will increase because a more expensive financing method would have to be used in lieu of IDBs.

We recognize that there have been abuses in the use of Industrial Development Bonds by some commercial firms. However, rather than totally eliminating IDBs for all firms, Congress should target its efforts at the specific abuses. Nursing homes and other health care institutions are appropriate users of IDBs and should not be penalized along with firms which have abused this benefit. Health care institutions, and nursing homes in particular, exist for the public good, provide necessary and critical services which benefit the community, stimulate the local economy, and create a significant number of jobs.

TAX INCENTIVES FOR FAMILY CONTRIBUTION TO ELDERLY HEALTH PAYMENTS

Despite Medicare and Medicaid, more than one-third of the elderly's health expenses are paid from private sources, usually personal out-of-pocket expenses. This situation will worsen as a result of government spending cutbacks in public health programs.

The number one health cost burden for the elderly or their families is nursing home care. In 1978, the private health care expenditure for the elderly was $747 per capita. Of that total $279, or 37 percent, went for nursing home care. Half of all catastrophie health costs are incurred by nursing home patients.

AHCA recommends that tax incentives be provided to encourage and help families contribute to this private cost burden until public benefits are expanded. Consideration should be given to such proposals as H.R. 3846 intoruced by Mr. Pepper to allow the deduction of nursing home and home health care expenses paid by families on behalf of their relatives.

Thank you for the opportunity to testify. We are pleased that the Subcommittee has addressed Medicare skilled nursing issues so early in the year. We are prepared to work with you so that this year the Medicare skilled nursing benefits can finally become what the beneficiaries need and think they have available.

Chairman JACOBS. Thank you, sir.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

We have been hearing a great deal recently of the problems in our reimbursement system for skilled nursing facilities, and therefore I am not surprised that you have suggested a new perspective in the reimbursement system.

Are there any major risks, however, for such facilities from a change of this kind? I realize most of them are for it, but are there any warnings that you think we ought to take into account to minimize the chance that some facilities would be worse off that way than they are today?

Mr. GUNNERSON. Congressman, I don't think that as providers we really have a responsibility to say to individual facilities or guarantee them that they won't be worse off.

Mr. GRADISON. But isn't there the possibility that this will be used along with some of the procompetition legislation which some of us are actively supporting to set a price in a community which would be the price that would be paid, which presumably would have no necessary relationship to cost, and people who want to participate in the program would have to meet the competition?

Mr. GUNNERSON. I think we are prepared to live with the competition. We would like, however, if the competition which is estalished is a major buyer, medicare or medicaid, that there be some rationale or formula so that we don't get to this problem.

We all recognize it takes x dollars to provide a service and we would not want the program as the major buyer of the service to say that it has concluded that its price would be x dollars minus something. I think there obviously have to be some protection for the providers as well as the programs.

Mr. GRADISON. Thank you very much.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank you. I have reviewed your statement. I apologize that I had to step out for a moment. I know you always do an excellent job and make an excellent presentation. Let me ask you this. Has the cost of home health care increased in line with other health care delivery costs in the country?

Mr. GUNNERSON. Congressman Duncan, I am not absolutely familiar, but I think generally the prices have increased comparably. I think the total dollars expended have risen substantially only because there is a great use of the service.

Mr. DUNCAN. But you are continuously monitoring that problem?

Mr. GUNNERSON. Oh, yes. I think anyone in the long-term care field watches both what is going on with hospital prices and what is going on in all aspects of long-term care programs, including home health care.

Mr. DUNCAN. What are your views for the future?

Mr. GUNNERSON. I guess I am an optimist by nature. I think that if Congress would come to grips, at least from the medicare standpoint, recognizing that we are only 2 percent of the medicare program, if Congress will come to grips with what we think is the single greatest weakness in the system, which is the retrospective payments, simply saying to providers "Spend what you have to, as you perceive to do the service, and we will calculate the rate afterward," and if we begin to establish some knowns up front so each of us knows what we are going to get paid for services, and know what number we have to compete with, then there are sufficient savings to be made throughout the system. I think we are just basically very optimistic.

Mr. DUNCAN. Thank you very much. Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Duncan.

Sam, if we have a shortage of nursing home beds as we do, there really isn't much, if any way, to rectify that situation without spending more money than we are spending now; is there?

Mr. GUNNERSON. Congressman, the shortage is not universal, and the answer is no; there is not. I think you have a basic problem, and that is that we have a population that continues to age. We are seeing, I suspect, rather remarkable increases in the length of life. We have a program right now called the skilled nursing facility program, in which we, effectively the individual out there, thinks if he is a medicare beneficiary he has 100 days of nursing home care.

In fact, his chances are something like 11 out of 1,000 of using the service and getting 30 days' worth. I think the real answer to your question, Congressman, is that we haven't come to grips with what we are going to do with the aged, but if we believe that we can do the job with less money than we are spending right now, we are living in never-never land.

Chairman JACOBS. Did you by chance read the piece in the current Newsweek by a man named Schwartz who is a writer in residence at Columbia University?

Mr. GUNNERSON. No, sir.

Chairman JACOBS. You couldn't very well comment on it. I commend it to your attention. It is a provocative, controversial piece on the subject. We are grateful to you for your testimony.

Mr. GUNNERSON. Thank you.

Chairman JACOBS. The next witnesses represent the American Association of Homes for the Aging, Sister Marie Michelle Peartree, president-elect. We have at least one person in the room that looks like a president already. Sister, will you proceed.

STATEMENT OF SISTER MARIE MICHELLE PEARTREE, PRESIDENT-ELECT, ADMINISTRATOR, ST. ANN'S/THE HERMITAGE HOME, ROCHESTER, N.Y., ACCOMPANIED BY LAURENCE F. LANE, DIRECTOR OF PUBLIC POLICY, AND ALAN K. PARVER, REPRESENTING AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Sister PEARTREE. My name is Sister Marie Michelle Peartree, and I am the administrator of St. Ann's/The Hermitage Home in Rochester, N.Y., a medicare-certified facility. I am also president-elect of the American Association of Homes for the Aging, and I appear today on behalf of that association. Accompanying me this morning are two members of AAHA's staff, Laurence F. Lane, director of public policy; and Alan K. Parver, legislative counsel.

Mr. Chairman, I would like to summarize our statement and have the entire text inserted in the record.

Chairman JACOBS. Without objection.

Sister PEARTREE. AAHA represents almost 2,000 not-for-profit providers of housing and long-term care for the Nation's elderly. Among our members are facilities which participate in the title XVIII—medicaid—program as skilled nursing facilities and intermediate care facilities.

I come before this subcommittee today to address several important issues raised in the continuing dialog devoted to improving the responsiveness of the medicare program to the needs of its beneficiaries and skilled nursing facilities. The subcommittee is to be commended for its timely interest in this area.

AAHA, of course, is eager to work with the subcommittee in its efforts to enhance the effectiveness of medicare in the context of skilled nursing facilities. While I intend to speak to the ramifications of a prospective reimbursement system and the deletion of the 3-day prior hospitalization requirement, I also want to focus on the spell-of-illness issue, comment on the present discussion on dual participation, and raise the issue of the medical social services prohibition.

We have long supported the principle of prospective reimbursement, which acknowledging that there has been a noticeable lack of consensus on the proper method of implementing such a system. Because of the controversy surrounding the development of a prospective system, we look with favor upon the flexible approach of Congressman Wyden in H.R. 5084, which deals only with hospitals.

That bill would establish the principle of prospective reimbursement for medicare, while leaving the particular method of constructing the system to the individual States. The adoption of prospective reimbursement would be strictly on a voluntary basis, a

provision which we applaud. This approach could be an effective one regarding skilled nursing facilities, and deserves serious study as a first step toward a nationwide program. At least at the beginning stages, State initiative should be encouraged in the development of a prospective mechanism.

The various State reimbursement systems are too diverse to attempt to impose one particular medicare reimbursement standard. A nationwide method, without a clear basis or reliable supporting data, may well result in the defeat of the entire concept.

It should be noted that there is a present provision of law that would permit medicare prospective reimbursement to be approached on a State-by-State basis for SNF's. Section 249(b) of Public Law 92-603 established Section 1861, 1861(V)(1)(E) of the Social Security Act, which provides that cost reimbursment methods which the Secretary finds to be acceptable for a State's medicaid program can be adopted for purposes of medicare skilled nursing facility reimbursement in that State.

Thus a prospective reimbursement method, medicaid can legally be applied, with adjustments where appropriate, so as to construct a medicare prospective reimbursement system for a State's SNF's.

The Department of Health and Human Services has never issued regulations to implement this section. This is unfortunate, because the trend toward integrated health facilities can only be enhanced by a relatively uniform method of reimbursement within a particular State for both medicare and medicaid. Section 249(b) offers a means out of the morass surrounding the inconclusive debate involving the nationwide application of prospective reimbursement.

If the Department of Health and Human Services moves to implement it, Section 249(b) could enable the country to move toward the goal of medicare prospective reimbursement for SNF's, while allowing for the restraints and pitfalls that are inevitable in an evolving care system.

Both section 249(b) and the principles embodied in H.R. 5084 offer, in our view, the best present means of achieving a prospective reimbursement system in the least disruptive manner.

We hasten to add that there are aspects of H.R. 5084 that we find questionable, particularly in contemplating its possible application to SNF's. Specifically, we doubt whether the voluntary acceptance of prospective reimbursement should extend to the substate level in circumvention of the State government.

Instead, we would suggest that substate or individual facility participation in a prospective reimbursement system, in the absence of a statewide system, could be better achieved through the existing waive authority.

We believe there is merit in eliminating the 3-day hospitalization requirement for skilled nursing services. Data from the 1977 nursing home survey indicates that about half—54 percent—of the residents are admitted from a health facility.

This group was composed mainly of those admitted from a general or short-stay hospital—32 percent—and those transferred from another nursing home—13 percent. Forty-one percent, however, had moved from a private or semiprivate residence, where they had usually lived with others.

We believe that the 32 percent admitted from a general short-stay hospital could be drastically reduced if the prior hospitalization requirement were not imposed. This would result in a cost savings to the program, because the medicare rates for SNF's are substantially less than that for hospitals. Abusive practices could be minimized by: One, the requirement for a costly first-day deductible which could make it prohibitive to have a convenience stay in a facility, and two, the increased tightening of utilization review and PSRO long-term care review instruments.

This issue, also, should be viewed in light of developments affecting the programmatic requirements for SNF's. While the conditions of participation are specifically excluded from the agenda for today's hearing, it should at least be noted that, since the 1974 conditions of participation, there has been a significant growth in the professionalism of the medical staffs of SNF's.

The development of institutional expertise, along with the expanded use of multidisciplinary patient assessment, offer substantial added safeguards against the misapplication of medicare funds for nursing care.

The maturing of the industry has led to heightened efforts toward insuring appropriate placement of residents within the long-term care system. An increasing concentration of emphasis on the psychosocial aspects of care, as required by regulation and advances in the art, is a further guarantee that acute care services reimbursable by medicare in SNF's will not be abused.

AAHA has been striving for years to change the current provisions relating to spell of illness, so as to focus on the particular services provided to a resident rather than the category of facility in which he/she resides. We would like to reiterate our position today for the subcommittee, and share with you, in our statement, our recommended statutory language. At the present time, spell of illness is defined in section 1861(a) of the Social Security Act, 42 U.S.C. section 13495x(a), as meaning a period of consecutive days:

(1) beginning with the first day—not included in a previous spell-of-illness—
A. on which such individual is furnished inpatient hospital services or extended care services . . . and
(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility.

In interpreting this provision, HHS has observed a strict objective test: The nature of the facility, rather than the nature of the services rendered therein, determines whether one is an inpatient under the cited statute. The result has been that a resident of an extended care facility, even if receiving no medical care at all, is considered under the spell of illness as long as he/she is still in that facility. Thus, medicare eligibility can often run out despite his/her actual health, or the services rendered by the institution.

Several court decisions have held that mere residencey, where only custodial, will not operate to extend a "spell-of-illness" (*Swenson* v. *Finch,* 1970; *Hardy* v. *Mathews,* 1976; *Hasek* v. *Mathews,* 1977; and *Gerstman* v. *Secretary of Health, Education and Welfare,* 1977; *Burt* v. *Secretary of Health, Education and Welfare,* 1979.)

Unfortunately, HHS has taken only limited action to conform to the above-mentioned series of court decisions. While option papers

have been circulated by midlevel staff, the Department has failed to modify its interpretation and revise the provider manual. Officials of the Health Care Financing Administration contend that before the rules can be modified, the statute must be clarified. In the 93d Congress, the U.S. Senate passed a clarification of the spell-of-illness provision as section 198 of H.R. 3153. However, this legislation was never reported from conference.

We are proposing the following amendment to clarify this issue:

Amend section 1861(a)(2) of the Social Security Act to read as follows:

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither furnished inpatient hospital services—as defined in section 1861(b) or extended care services—as defined in section 1861(h) reimbursed under Part A of this title nor under a State plan approved under title XIX.

Amend section 1861(j) by striking the phrase:

For purpose of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.

The spell of illness commences with the first day that an individual is furnished inpatient hospital services or extended care services which occurs in a month for which he is entitled to benefits under part A. The end of the spell of illness should also be premised on the provision of furnished services, not placement. The court's decision in the *Hasek* case points out:

Had Congress desired to make the nature of the facility all-determinative, it would not have used the term "inpatient," but would have merely required that one be in, or a resident of, a facility. It did not do this, and the clear and reasonable interpretation of that one who is receiving none of the enumerated services, and cannot otherwise be defined as inpatient, is not precluded from having a spell of illness under section 1395x(a).

HHS has opposed this clarification of the act as preventing the Government from forestalling potential fraudulent acts. The Department contends that recipients might elect to break the spell of illness by receiving skilled care in a facility that does not participate in the medicare program. Such care would be paid for by the patient, and therefore, be beyond the control of the Department. The Department has contended that Congress wanted the Department to police these potential patient shifts, refering to the definition of skilled nursing facility under section 1861(j), which is cross-referenced to the spell-of-illness provision.

Congress must clarify its intent to prevent a continued problem in dual certified facilities. We must be conscious of the findings by the National Center for Health Care Statistics, which points out in its preliminary findings in the 1977 Nursing Home Survey:

The disparity between the residents' and the discharge length of time in the facility suggests that there are two separate groups of persons who use nursing homes: those admitted for relatively long periods of time because there is little chance of their chronic problem improving, and those admitted for relatively short periods of time because recuperative care is needed.

We must also be conscious of the findings that:

The poor health of many in the discharged population is reflected in the findings that 25 percent of all discharges died in the nursing home and 45 percent of all live discharges were transferred to a general or short stay hospital, presumably to receive more intensive care.

For years, AAHA, along with other groups, has been urging the Congress to proceed cautiously on any proposal which would require SNF's participating in the medicare program to also be medicaid certified. While we are supportive of the intention behind such a proposal to increase the availability of nursing beds, we believe that it could potentially result in a decrease in the number of nursing beds which are medicare and medicaid certified.

Thus we welcomed Congress inclusion within the Omnibus Budget Reconciliation Act of 1980 of the provision directing DHHS to study the availabiliy of and need for SNF's services covered by medicare and medicaid. The study was also to determine whether there is a shortage of skilled nursing beds for medicare and medicaid residents, and to judge whether laws and regulations contributed to that shortage.

Further, Congress requested that the study look at the feasibility of requiring nursing homes to become dual certified.

The requested study, which was done by the Urban Institute, has recently been completed. It is an exhaustive analysis of the topic areas prescribed by Congress. It is now incumbent on the Congress to address the problems and issues cited in the report. Among the major findings of the study are the following:

Almost all—96 percent—homes participating in medicare already participate in medicaid; hence mandating medicaid participation would have almost no impact;

Requiring all homes in medicaid to participate in medicare would not appreciably increase medicare beds in 7 of the 10 States with the lowest medicare bed supplies. In these States, most medicaid homes already participate in medicare;

In other States, requiring medicaid homes to participate in medicare would increase the number of medicare beds; but some homes would give up their "skilled" classification in order to avoid medicare participation;

Under existing payment rules, medicare would not pay the full cost of the operating requirements mandatory participation would impose; costs would be shifted to medicaid and private patients;

Although greater participation would induce some increase in medicare use, medicaid homes required to participate in medicare would still prefer patients who require less care and stay longer than medicare patients;

Requiring all medicaid homes to participate in medicare would increase billings to medicare even with no change in access, as States enforced provisions making medicaid a payer of last resort;

With mandatory participation in medicare—federally or State-imposed—medicare liabilities would increase, unless medicare maintained thorough claims review against its specific coverage criteria.

As the report indicates, requiring dual participation without modifying payment rules could be disastrous. Instead, we would urge the subcommittee to explore means of countering the presently inadequate reimbursement rates which, in many cases, preclude a nonprofit facility from maintaining its financial viability without significant community and philanthropic support.

We have constantly fought the potential trade-offs that may have to be made if community support can no longer make up the in-

creasing deficits, that is, two-tier service delivery, cutbacks on creative and innovative services, a drift toward the almshouse approach of the 1930's.

The Urban Institute report is a useful tool which can be used to begin the development, in a meaningful way, of a means of increasing the number of facilities which are medicare and medicaid certified, without negative impacting on the services that long-term care facilities provide.

Section 1861(j)(15) of the Social Security Act prohibits the Secretary of DHHS from requiring as a condition of participation that medical social services be furnished in a skilled nursing facility. This section is the result of a deep concern by Congress that the social services function may be dominated by outside consultants and specialists. Perhaps that concern was justified at the time of the enactment of section 1861(j)(15).

However, in the last decade we have witnessed marked changes in the staffing and emphasis within nursing homes. As discussed earlier the professionalism of the facility staffs is a fact which should not be taken lightly. The evolution of patient assessment and the development of strong medical direction within the facilities should encourage the Congress to remove this provision from the law. We believe that the prohibition presently acts as a roadblock to the full development of an effective long-term car system.

The discharge potential of residents receiving the medicare benefit in SNF's is obviously reduced when there is no effort to respond to their pressing psychosocial needs. Indeed, it is often the social care that can mean the difference between a short-term stay and a long-term maintenance-oriented stay.

Further, it is not only the discharge population which would benefit from increased application of social services. The maintenance population, those residents for whom circumstances mandate a long-term care stay, can live and thrive in greater dignity through social care. Those persons who are part of the terminal population would also benefit to the extent that the facility can offer hospice-related services.

These are worthy and reachable goals, and we believe that public policy should encourage efforts designed to achieve them. We urge the Congress to take the necessary corrective action, and remove the restriction against medical social services in the statute.

Thank you for the opportunity to appear before you today. AAHA stands ready to work with the subcommittee in drafting the appropriate revisions in the medicare program.

Chairman JACOBS. Thank you, Sister. We appreciate the clear testimony.

Mr. Duncan?

Mr. DUNCAN. I have no particular question but I do wish to thank you for your excellent testimony. I know it will be of help to all of us.

Chairman JACOBS. It is well prepared. I suppose the only question is, if I understand it correctly Sister, your association is asking to be regulated in a fashion that it is not now regulated as a requirement of social services. That may be a little unusual. We have had fun. Thank you.

Sister PEARTREE. Thank you.

Chairman JACOBS. The final witness for today is Mr. Jack MacDonald, who represents the National Council of Health Centers.

Mr. MacDonald?

STATEMENT OF JACK A. MacDONALD, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CENTERS, ACCOMPANIED BY DONNA BARNAKO, DIRECTOR OF GOVERNMENT RELATIONS

Mr. MACDONALD. Thank you, Mr. Chairman.

I am Jack MacDonald. I have with me Donna Barnako, who is our director of government relations.

The national council is a membership organization composed of major multifacility nursing home companies throughout the country. We currently have more than 170,000 beds in 49 States. Our members also provide—in conjunction with the points that were raised earlier by Mr. Gradison—a wide spectrum of services, from home health services to hospice services to hospital care.

We are particularly pleased to come before your committee today to speak about an important but much neglected issue: The medicare skilled nursing facility benefit.

The national council has for years spoken out about the flaws in the medicare program. At the same time, we have worked with this congressional staff, as well as the Senate side, and the Department of Health and Human Services to try and address and correct some of these.

We appreciate the fact, Mr. Chairman, that your subcommittee has recognized the magnitude of the problem that has literally been undermining the health of our nation's elderly.

This practice dates back to the 1960's, when, as was mentioned earlier this morning, terminal cancer patients were classified as "custodial" and thereby denied coverage under the medicare program.

While we have been encouraged by recent changes in medicare's administrative policies made by Dr. Carolyne Davis, Administrator of HCFA, there are changes in coverage which can only be addressed through legislation.

There is a great deal of statistical data and case histories that are a testimonial to the failure of the medicare skilled nursing facility program to serve those for whom it was conceived.

Medicare program policies have so narrowly defined the benefit as to deny it to needy and eligible medicare beneficiaries. Unfortunately, this approach has evolved into a policy that is penny-wise and pound-foolish, as it has resulted in those same medicare beneficiaries costing the program more than one billion unnecessary dollars per year as they back up in hospitals waiting for nonexistent medicare nursing home beds.

My statement today will address three areas of concern where program modifications would undoubtedly lead to an improvement in benefit coverage, as well as cost savings, by reducing the hospital backlog.

These three areas are mandated dual certification, elimination of the 3-day hospital stay requirement, and instituting a prospective

reimbursement system. Concerning these three issues, I think there are two problems that need to be addressed very briefly.

First is the shortage of nursing home beds. Is there a shortage? While there are areas where there is a surplus, there is to a great extent throughout the country a shortage of SNF beds.

One need only look at the number of States reporting serious backlogs of hospital patients awaiting medicare or medicaid beds to see the gravity of this problem. These States include California, Washington, Georgia, Massachusetts, Connecticut, Michigan, Minnesota, New York, and the District of Columbia.

Data from individual States is supported by further national data indicating that 250,000 administratively necessary days were used in the first quarter of 1979, and that "backup patients" average 10 percent of a hospital's occupancy.

Little computation is needed to figure savings to be gained by substituting a $40 per day rate in a nursing home for a $300 daily rate in a hospital. It is indeed an understatement to say that the program's policy of restricting the access of medicare patients to nursing homes is both shortsighted and costly.

The second problem for medicare patients, that of their access to skilled beds, has become a vicious circle. The systematic tightening of eligibility has led to a denial coverage of medicare SNF patients while at the same time the lack of patients has increased the cost of the burdensome reporting requirements along with the retroactive denial of claims has led to decrease in certified beds. As a result in many States, we have a combination of a short supply of existing beds, with more facilities withdrawing from the medicare program every day.

A recent report which was cited previously by the witness from the American Association of Homes for the Aging concerning the Urban Institute has characterized the reduction in covered SNF days under medicare as both larger and more pervasive than previous changes.

That same study points out that covered days per aged person have declined in 38 States with more than a 10-percent drop in 27 States. This is occurring at a time when both the demand and the number of eligible beneficiaries is increasing.

We would suggest that since this study was a matter of congressional mandate, contained in the 1980 Omnibus Reconciliation Act—and I believe it is one of the reports that the department has signed off on—that the subcommittee may wish to review this report.

In terms of the statistics and the dramatic drop in the utilization, I would point out that in the 10 years between 1968 and 1978, the number of approved skilled nursing facility claims decreased by 28 percent, from 1 million to 784,000. The number of days of care decreased 127 percent, from 19.5 to 8.6 million.

At the same time, there has been an increase in hospital claims of 71 percent, from 5.1 to 10.1 million; an increase in covered days, from 75 to 101.1 million. There is a typographical mistake in our written statement, the "10" should be 100. In terms of this, a two-pronged problem has arisen. I would point out that it is not going to get any better.

We have done certain projections in terms of the need for existing beds to expand. Our conservative estimate is that if we are to serve by 1990 the same percentage of the elderly American population that we do today, which is approximately 5 percent, we will need approximately 250,000 beds. That has also been estimated as high as 300,000 beds. That is a capital cost of approximately $12 billion, accounting for inflation. That is if we are to build the beds to meet the increased demographic demands.

In the history of the Hill-Burton program, which I believe covered about 26 years, I believe the number of dollars that were spent were approximately $4.7 billion.

Chairman JACOBS. I assume those are not adjusted for inflation. You are not comparing the two, are you?

Mr. MACDONALD. I am saying we spent during the history of the Hill-Burton program, in terms of trying to build our hospitals, $4.7 billion over approximately 26 years.

Chairman JACOBS. But you are not comparing those dollars with the ones you are talking about now?

Mr. MACDONALD. No, I am saying adjusting for the $12 billion includes an adjustment for inflation over the next 10 years, so that our problem in terms of the utilization of resources—and that is what we are talking about here—really boils down to how do we eliminate the current barriers that may exist in our medicare-medicaid program coverage.

We feel that one of those avenues is what is being addressed here in this hearing concerning the 3-day prior hospitalization stay. In the past, this subcommittee and the full Ways and Means Committee eliminated that 3-day prior hospitalization for home health services. We feel that the same logic applies in terms of both home health services and nursing home services.

I would point out the fact that in Congressman Duncan's home State, one of our members is operating at the present time 14 home health services out of their nursing homes in conjunction with the providers of health care services in those communities, and they are finding that the length of stay per incident has gone down.

It has not had a direct impact in terms of the census in those facilities, but what should be important to all of us is that the cost per incident to the public is being decreased.

We feel that one of the steps that would further assist this is the elimination of that 3-day hospital requirement for the purposes of nursing homes.

In terms of prospective reimbursement, as the other statements have all stated today, we strongly endorse a movement toward prospective reimbursement. We do that for both purposes of our home health services and our nursing home services.

The issue of spell of illness was addressed earlier and is a part of our current statement that I have submitted.

The other item that I would call your attention to is the fact that we feel there is a strong need for bringing about a uniformity in the coverage definitions that are being applied around the country by the intermediaries.

We have seen and it was identified in the Urban Institute report that there is a discrepancy in terms of the definition of covered services for skilled benefits, and it also happens in the other areas

of home health and hospitalization between intermediaries. We feel that this problem needs to be addressed.

In conclusion, I appreciate this opportunity to appear before you today. If you have any questions about our submitted statement or any of the other materials that we will be sending along to you, I will be more than happy to answer them.

Chairman JACOBS. Thank you.

[The prepared statement and a portion of the Urban Institute report referred to follow:]

STATEMENT OF NATIONAL COUNCIL OF HEALTH CENTERS AS PRESENTED BY JACK A. MACDONALD

Mr. Chairman, members of the Subcommittee, my name is Jack MacDonald and I am Executive Vice President of the National Council of Health Centers.

The National Council membership is comprised of the major multi-facility nursing home firms with more than 170,000 beds in nursing facilities in 49 states. Our members also provide many other long term care services to the elderly such as home health, adult day care and retirement communities.

We are particularly pleased to come before your Committee today to speak about an important but much neglected issue: the Medicare skilled nursing facility benefit. The National Council has for years spoken out about the flaws in the Medicare program. At the same time, we have worked with congressional staffs including the Ways and Means Committee, as well as the Department of Health and Human Services to try to correct some of them. We appreciate the fact, Mr. Chairman, that your subcommittee has recognized the magnitude of the problem that has literally been undermining the health of our nation's elderly. This practice dates back to the 1960's when, for example, terminal cancer patients were classified as "custodial" and thereby denied coverage under the Medicare program. While we have been encouraged by recent changes in Medicare's administrative policies made by Dr. Carolyne Davis, Administrator of HCFA, there are changes in coverage which can only be addressed through legislation.

There is a great deal of statistical data and case histories as testimonial to the failure of the Medicare skilled nursing facility program to serve those for whom it was conceived. Medicare program policies have so narrowly defined the benefit as to deny it to needy and eligible Medicare beneficiaries. Unfortunately this approach has evolved into a policy that is penny wise and pound foolish as it has resulted in those same Medicare beneficiaries costing the program more than one billion unnecessary dollars per year as they back up in hospitals waiting for nonexistent Medicare nursing home beds.

My statement today will address three areas of concern where program modifications would undoubtedly lead to an improvement in benefit coverage as well as cost savings by reducing the hospital backlog. These three areas are mandated dual certification, elimination of the three day hospital stay requirement, and instituting a prospective reimbursement system.

STATEMENT OF THE PROBLEM

1. Shortage of nursing home beds

Is there a shortage of nursing homes beds? The answer to this question is quite simply yes. A few areas of the country might have an excess of beds, but they are the exception rather than the rule.

One need only look at the number of states reporting serious backlogs of hospital patients awaiting a Medicare or Medicaid nursing home bed to appreciate the magnitude of the problem. These states include, to name only a few, California, Washington, Georgia, Massachusetts, Connecticut, Michigan, Minnesota, New York, and the District of Columbia. Data from individual states is supported by further national data indicating that 250,000 administratively necessary days were used in the first quarter of 1979; and that "backup patients" average ten percent of a hospital's occupancy.[1] Little computation is needed to figure savings to be gained by substituting a $40 per day rate in a nursing home for a $300 dollar daily rate in a hospital.

[1] American Association of Professional Standards Review Organizations, "Long Term Care One Day Census," Potomac, Md., Sept. 4, 1980.

Department of Health and Human Services, Office of the Inspector General, Service Delivery Assessment, "Secretarial Report: Restricted Patient Admittances to Nursing Homes; An Assessment of Hospital Back Up," September 1980.

It is indeed an understatement to say that the program's policy of restricting the access of Medicare patients to nursing homes is both shortsighted and costly.

2. Utilization decreases

The problem of the access of Medicare patients' access to skilled nursing beds has become somewhat of a vicious circle. The systematic tightening of eligibility and uncertainty of coverage leads to fewer Medicare SNF patients while the lack of patients, burdensome reporting requirements and retroactive denial of claims has led to a decrease in certified beds.

A recent report by The Urban Institute has characterized the reduction in covered Medicare SNF days as "both larger and more pervasive than previous changes." That same study points out that covered days per aged person have declined in 38 states, with more than a ten percent drop in 27 states. This is occurring at a time when both the demand and the number of eligibles are increasing.[2]

Mr. Chairman, we would ask that this excellent study by The Urban Institute be entered into the Record of this hearing. The study was conducted as a result of a Congressional mandate in the 1980 Omnibus Reconciliation Act to examine the reasons why skilled nursing facilities refused to participate in the Medicare program.

Some additional statistics provide an equally strong indictment of the Medicare program:

In the ten years between 1968 and 1978 the number of approved skilled nursing facility claims decreased 28 percent from one million to 784,000; the number of days of care decreased 127 percent from 19.5 million to 8.6 million. At the same time there has been an increase in hospital claims of 71 percent, from 5.9 million to 10.1 million; and an increase in covered days from 75 million to 10.1 million.

Now that I have outlined the extent of the problem, I would like to discuss some of the reasons for it.

CAUSES OF THE PROBLEM

Just as statistics clearly substantiate the declining Medicare SNF coverage and lack of certified beds, the reasons for this decline are equally apparent.

The basic definition of what constitutes skilled nursing care is in itself quite narrow, however this has been so refined and confined by federal interpretations and regulations so as to be even more restrictive than specified by law.

To add to the difficulties, each intermediary has his own interpretation of what actually constitutes skilled nursing care under Medicare.

Rarely does Medicare cover the skilled supervision of an aggregation of unskilled services although it is specifically provided for in the law.[3] A report by the New York State Office of Health Systems Management declares that "Medicare's application of this Section is so restrictive that it negates obtaining Medicare benefits under these provisions."[4]

Coverage is further denied when a patient's restorative potential is reached or when he has no restorative potential at all. In terms of a real life situation, terminal comatose cancer patients can and are being denied Medicare coverage because they have no rehabilitative potential.

Mr. Chairman, we think these types of situations are a travesty of the and should be stopped. It is not hard to see why patients get backed up in hospitals if the alternative is losing their Medicare coverage.

From the perspective of our multifacility members, the variation in coverage interpretations from state to state is confusing and frustrating. What may be covered in one state is not in another. A single facility faces equal problems because it is the nursing home's professional responsibility to determine if a patient would be covered by Medicare and the nursing home is at financial risk if the intermediary indicates that a wrong determination was made.

Requiring the nursing home to make the determination of a patient's Medicare coverage and then to be at financial risk retroactively for that decision is a serious shortcoming of the program. This policy contributes greatly to the reluctance of nursing homes to participate in Medicare.

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[2] Judith Feder and William Scanlon, "Medicare and Medicaid Patient's Access to Skilled Nursing Facilities," The Urban Institute, November 1981.

[3] 20 CFR 404, section 405.127.

[4] New York State Office of Health Systems Management, Department of Social Services, "Medicare Skilled Nursing Benefit—Background/Overview"; Mar. 5, 1979, p. 9.

As the New York State report points out,[5] Medicare specifically allows for presumptive coverage of Medicare benefits on the basis of a physician's certification of SNF level of care need.[6] While this certification does occur, it is not accepted as a final decision, nor do most physicians sufficiently understand the intricacies of eligibility to correctly inform their patients. As a result patients have very high expectations as to coverage, and they are almost always disappointed. Unfortunately, explanatory pamphlets distributed by federal agencies do little to dispell these expectations.

A report compiled by a Medicare Task Force of the Minnesota Foundation for Health Care summarized the perceptions and misperceptions about the Medicare program held by concerned parties in that state.[7] Physicians commonly believe that all skilled care is covered for up to 100 days. Consumers expect that any nursing home care will be covered for 100 days. Unfortunately, both of these conceptions are far from the truth as only about three percent of the patients in nursing homes are covered by Medicare and the average length of stay is only 24 days.

A look at the enormous variation in Medicare SNF coverage from state to state provides ample evidence of a systematic effort to deny benefits in at least 38 of them. The Urban Institute study pointed out that when comparing variances among states, the highest hospital stay rate was only 76 percent larger than the lowest, compared to a more than one thousand percent difference for SNFs.

We are frankly mystified why comsumers are not up in arms over this situation and the inequities it has caused. They could not be faulted for simply demanding the benefits to which they are entitled nor would those members of your committee or other members of Congress be wrong in seeking redress, for these people are your constituents.

As nursing home providers, our members every day see unhappy real life examples of the statistics which I have cited. In hope of resolving these problems we are bringing them to your attention. We feel that consumer groups could well play a positive and constructive role in this regard. As members of the committee with jurisdiction over Medicare you, however, can play the most important role by enacting legislation to rectify the inequities and problems we have outlined. This legislation includes Congressman Wyden's bill, HR 4227, calling for elimination of the three day prior hospital stay requirement. We also urge you to consider enacting legislation which would permit prospective reimbursement for nursing homes under Medicare.

At the same time, we will continue to seek changes in regulations which will improve the administration of the Medicare program.

RETROSPECTIVE REIMBURSEMENT

Much of the dissatisfaction nursing homes have with the Medicare program can be traced to its retrospective system of reimbursement.

The complexity of retrospective reimbursement and its cost reporting requirements has forced nursing homes to hire CPA's with Medicare experience just in order to remain in the program. It is also the reason that many smaller homes and single facilities have been dropping out. When so few patients meet the Medicare eligibility requirements and then for only a few days' time, it is simply not worth the extra effort involved to maintain Medicare certification.

The case against Medicare's retrospective reimbursement is almost overwhelming. It is cost inflationary, provides no incentives for efficiency, nor for containing costs. Perversely, it rewards the inefficient provider: those who spend more, get more. At the same time, costs accepted as legitimate business expenses in all other sectors of our economy are not recognized by Medicare. The system of allocating portions of costs to various cost reporting centers is inappropriate and unnecessarily complex in the context of a nursing home.

In discussing the disadvantages of retrospective reimbursement, a study by the Battelle Institute noted, "The more complicated the system, the more likely the system will be unenforceable. Every additional cost item reviewed, audited, or monitored represents a further dilution of monitoring resources, and each additional regulation requires additional effort to assure compliance by the industry." [8] Because

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[5] Op. Cit.

[6] 20 CFR 405, section 405.133.

[7] Minnesota Foundation for Health Care Evaluation, Medicare Task Force Report—Issue Paper and Recommendations, June 3, 1981.

[8] Battelle Human Affairs Research Centers, under contract to the Health Care Financing Administration: "Profits, Growth, and Reimbursement Systems in the Nursing Home Industry." April 1981, p. 225.

of the importance of the issues and findings of this report, I would respectfully request that it be included as part of the Record.

Another problem resulting directly from retrospective reimbursement is the retroactive denial of claims. It is no wonder that nursing homes are overly cautious in making decisions regarding Medicare coverage, because neither the nursing home nor the patient's physician has final say. Ultimately it is a clerk in the office of the intermediary who makes that decision based on forms which have been submitted and a manual which he or she consults. If a nursing home guesses wrong in claiming Medicare coverage for a patient, it is in effect punished, by having its reimbursement denied.

That retroactive denial of claims has been a problem is evidenced by past efforts to correct it: such as presumed coverage, front end review by intermediaries, and waiver of liability. None of these approaches worked nor do we believe that serious attempts were made to make them work because of the objective to reduce their utilization of Medicare SNF benefits to the absolute minimum.

Let me make clear that we are not advocating a total opening up of the Medicare program. We do not believe that this would be practical or acceptable. We do feel strongly, however, that some minimal adjustments in the coverage requirements would reduce or eliminate the hospital backlog and thus the savings gained would more than offset the increased Medicare SNF costs. Equally important, we are only recommending coverage of benefits for Medicare patients that were promised the people of this country when the Medicare program was originally enacted. The two legislative issues which your Subcommittee is focusing on today, can do much to resolve the problems I have outlined and I would like at this point to discuss them further.

H.R. 4227—ELIMINATION OF 3-DAY PRIOR HOSPITAL STAY

As early as 1976 a HEW report, "Forward Plan for Health,"[9] endorsed elimination of the three-day stay stating, ". . . experience suggests that significant numbers of Medicare beneficiaries now receiving hospital care would benefit as much from SNF care . . ." and ". . . it is probable that patients in need of only skilled nursing care, and who are now instead hospitalized are never subsequently transferred to an SNF because of paperwork (eg, transfer of medical records, treatment plan) and the lack of any financial incentive or disincentives (eg, no cost sharing is required after first hospital stay and until the 61st day)."

In discussing potential savings, the "Forward Plan for Health" goes on to say, "since the average Medicare cost of a covered day in SNF is less than one-third the routine cost per day in a hospital, the potential cost savings is obvious."

Mr. Chairman, much has happened in the intervening six years since HEW made that recommendation. Most notable is that hospital costs have now escalated to $200 to $400 per day. It goes without saying that keeping any patients out of hospitals who don't need to be there would save millions of dollars.

Even the Abt study, which evaluated four years of data and went to painstaking lengths to conservatively estimate savings and to err on the side of cost increases, found a significant savings in this proposal.[10] We find it somewhat puzzling, then, that the Health Care Financing Administration is attempting to discredit its own study for which several hundred thousand dollars were spent just to evaluate the results. In this case we believe that government actuaries are attempting to discount or discredit a demonstration project which took three years and in which every precaution was taken to assure creditable results. Clearly HCFA did not expect the study results, but its response calls into question the value of having demonstration projects at all.

Pursuing HCFA's rebuttal of Abt's findings further, to completely discount any potential savings because an empty hospital bed would be paid for anyway under cost reimbursement points to the ludicrous nature of Medicare's reimbursement system, not the validity of the study's results. We do not believe that HCFA would want to disseminate very widely this line of reasoning nor would it stand up under scrutiny. To imply that a hospital bed would be paid for by Medicare whether it is empty or not would seem to indicate a casual attitude towards restraining medical

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[9] Department of Health, Education, and Welfare, Public Health Service, "Forward Plan for Health," 1976.

[10] Abt Associates, Evaluation of the "Three Day Waiver Skilled Nursing Facility Demonstration Project," Oct. 15, 1981.

care costs that is certainly contrary to the expressed concerns of the President and the Secretary. We do not believe this is the case.

Physicians freely admit that they place their patients in hospitals solely to qualify them for the Medicare SNF benefit.[11] Many of these patients never find their way to the nursing home because a bed might not be available or because they help a sagging hospital utilization rate and are never discharged.

Maintaining hospital occupancy can be a critical factor especially when occupancy rates nationally remain at 75%. An HHS Region 10 study noted the effect of low hospital occupancy levels by citing the policy in one state to penalize through lower reimbursement, hospitals with occupancy rates less than 85%. The report states "where there is a deliberate penalty, there is certainly an economic incentive to maintain occupancy rates."[12]

The American Medical Association House of Delegates has long supported the elimination of the three day prior hospital stay requirement and a similar restriction on home health benefits was repealed by the Congress last year. The same logic which Congress accepted in enacting that bill also applies to skilled nursing facilities: if a patient is ill enough to meet the skilled eligibility requirement, then he should not have to enter a hospital for three days in order to qualify for it.

The Abt study found that many patients who entered the nursing home directly under the waiver, were terminal cancer patients, those for whom heroic and costly life saving treatments are unnecessary. Other patients were at an intermediate care level and became more ill, making them eligible for Medicare. These patients would routinely have entered the hospital in order to qualify.

We strongly commend Congressman Wyden for proposing H.R. 4227, and note that Senator Heinz has introduced an identical bill S. 1754 on the Senate side. We urge you to give serious consideration to this legislation which would eliminate an unnecessary requirement and assist Medicare patients in obtaining the benefits which they are entitled to.

PROSPECTIVE REIMBURSEMENT

Mr. Chairman, as noted earlier, we believe that the Medicare retrospective reimbursement system is archaic and inappropriate. The Battelle study to which I referred earlier suggests that "Rather than trying to monitor and control the behavior of 18,000 individual nursing home attention should be directed to the design of a payment system for nursing home services in which incentives for the efficient use of resources are built into the system. There would then be no need for expensive if not impossible monitoring and control of the nursing home industry."

We endorse this recommendation wholeheartedly and believe that a prospective payment system fulfills these requirements perfectly.

Any payment system, to work appropriately, needs to be built upon both incentives and disincentives. Retrospective reimbursement provides only disincentives: costs are disallowed, ceilings are imposed, no opportunities are provided for sharing in savings, the cost of capital is inadequately reimbursed and there is no consideration of the patient or his needs.

We suggest that the fundamental principle of an effective payment system is the promotion of quality care of a reasonable cost. This can only be achieved if the health delivery system and the payment system are closely coordinated to attain a high degree of commonality of purpose. There are basically six goals which the health delivery system and the payment system should share.

I would like to list those goals and then submit for the Record a more detailed description of them.

1. The establishment of quality levels of service.
2. The encouragement of efficiencies in the delivery of service.
3. The encouragement of orderly growth.
4. Incentive for the patient to seek the cost effective provider.
5. The rewarding of efficencies.
6. Administrative simplicity.

The major determinents in developing an effective system are the principles which are used as a base for the methodology of payment. There are many principles or conditions which may be applied to a payment system, but there are eight which must be present if the system is to be effective.

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[11] Select Committee on Aging, U.S. House of Representatives," Medicare After 15 Years: Has It Become a Broken Promise to the Elderly?", Nov. 17, 1980.

[12] HHS, Region 10, Office of the Inspector General Service Delivery Assessment, "Restricted Patient Admittance to Nursing Homes, An Assessment of Hospital Back Up," August 1980.

1. Rates and charges must be determined prospectively.
2. Profit or a growth allowance is an integral part of the operating costs for both profit and non-profit facilities.
3. The payment system must encourage cost containment.
4. All rates should be related to patient assessment.
5. An allowance for the cost of capital.
6. Need to apply a quality assurance penalty.
7. Rates need to recognize standard cost elements.
8. The availability of an appeal procedure.

These are merely the basic elements which we believe, any prospective system must embody. The fact that 38 states already reimburse prospectively for Medicaid services should be strong incentive for doing the same for Medicare. It is both illogical and inefficient to have two separate payment methodologies in effect in a 100 or 150 bed nursing home. Medicare's disallowances, non-covered costs, ceilings, and retroactive denials are disincentives which have nevertheless failed to restrain costs.

Various proposals for prospective reimbursement are being discussed and we welcome the dialogue. Many of the problems of Medicare—paperwork, complexity, inflationary aspects, could be eliminated simply by implementing prospective reimbursement. We are encouraged that HCFA and members of Congress are now giving this issue important consideration. We stand ready to assist in that effort as deemed appropriate.

OTHER CONSIDERATIONS

While prospective reimbursement will do much to improve Medicare, there are other related issues which must be considered as well.

For example, there is a need for a common definition that is a compromise between that of Medicare and Medicaid. Certainly, those areas in which intermediaries have gone beyond the context of the law should be changed. There is also the need for some minimum coverage or precertification for Medicare benefits.

There is no doubt but that nursing homes have valid reasons for not wishing to participate in Medicare—these very adequately described in the Urban Institute study. Until these problems are resolved, it makes no sense to require dual participation for that will only increase costs while not helping to improve access.

Mr. Chairman, and members of the Subcommittee, we commend you for focusing attention on these very important issues. In a previous hearing in my home state of Washington Congressman Don Bonker called the denial of Medicare benefits "A full scale national crisis."[13] We urge your Committee to turn your efforts to eliminating this crisis by enabling Medicare beneficiaries, your constituents, to gain the benefits which are rightfully theirs, while at the same time, improving and simplifying the Medicare program.

EXCERPT FROM THE URBAN INSTITUTE WORKING PAPER "MEDICARE AND MEDICAID PATIENTS' ACCESS TO SKILLED NURSING FACILITIES"

I. INTRODUCTION AND SUMMARY

A. Origins of the study

In the Omnibus Reconciliation Act of 1980, Congress directed the Department of Health and Human Services to study the availability of the need for skilled nursing facility services covered by Medicare (Part A) and Medicaid. This report presents the findings of Urban Institute research conducted to provide HCFA with the information and analysis Congress requested. Specifically, the report reviews the evidence on problems Medicare and Medicaid patients face in obtaining covered skilled care and analyzes the characteristics of the nursing home market that create access problems for some patients.

To assure that our research addressed HCFA concerns, we worked closely with our project officer, Philip Cotterill, and discussed our plans and results with a committee of Department officials. As Congress requested, we consulted extensively with professional organizations, health experts, private insurers, nursing homes and consumer representatives in the course of the study. A list of the individuals and groups consulted is presented in the Appendix.

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[13] House Select Committee on Aging, Hearing on Medicare Program, Longview, Wash., Aug. 7, 1979.

B. Skilled nursing home care

Skilled nursing homes represent only a part of the nursing home market. Nursing homes provide a wide range of services to primarily elderly patients (86 percent) with very different needs.[1] The spectrum of services ranges from skilled nursing and rehabilitative therapy delivered by professionally trained personnel to personal care assistance with activities such as walking, getting in and out of beds and chairs, toileting and eating.

Since the 1972 amendments to the Social Security Act, homes wishing to participate as skilled nursing facilities (SNFs) in Medicare or Medicaid must satisfy a common set of standards.[2] An institution has to have a transfer agreement with one or more hospitals to provide a complement of services. The facility has to be primarily engaged in providing skilled nursing care and to maintain twenty-four hour nursing services by at least one full-time registered nurse. Although a physician need not be part of the staff, the health care of each patient must be under the supervision of a physician and a physician must be accessible to render emergency care. A facility must also operate a program of independent medical review of patients to assess progress and continued appropriateness of placement. A SNF must meet applicable state licensing laws and regulations and must conform to the Life Safety Code.[3]

Federal law also establishes standards for facilities providing less intensive skilled services, that is, intermediate care facilities (ICFs). Services in ICFs are covered by Medicaid but not Medicare. To be an ICF, an institution must provide health related care and services to clients who need a less intensive institutional care than that which SNFs or hositals are designed to deliver. An ICF is not required to have a registered nurse on duty 24 hours per day. Rather, it must have an RN or LPN, seven days a week, on the day shift to supervise the provision of health services. An ICF must also comply with applicable state licensing laws and regulations and must conform to the Life Safety Code.[4]

State licensing laws and HCFA regulations allow facilities to provide both skilled and intermediate level care. In some instances, separate parts of the faciliy will be equipped and staffed to meet the skilled care standards and other parts to meet the intermediate care standards. In other cases, the same beds may be used as skilled or intermediate, dependent on the patients who occupy them.

The vast majority of nursing homes are certified to participate in Medicare or Medicaid. The 1977 National Nursing Home Survey estimated that 25 percent of facilities were not participating in either program.[5] These facilities were smaller than most nursing homes and represented only 12 percent of nursing home beds.

There are almost 15,000 facilities that participate in Medicare or Medicaid (Table I-1). Approximately half have at least some skilled level beds. Forty-two percent of those participate only as skilled facilities, while the remainder have both skilled and intermediate beds.

TABLE I–1.—NUMBER OF MEDICARE OR MEDICAID CERTIFIED FACILITIES AND BEDS, BY FACILITIES' CERTIFICATION STATUS

	Facilities	Percent	Beds
SNF	3,314	22.9	299,657
ICF	6,872	47.5	549,868
SNF–ICF	14,291	29.6	[1] 364,314 [1] 151,610
All certified facilities	14,477	100.0	

[1] First number is skilled beds; second is intermediate beds. Some beds in joint SNF-ICFs are certified for both levels of care so that unduplicated counts of certified beds in these facilities are not available.

Source: Derived from Medicare-Medicaid Automated Certification System Data, Health Standards and Quality Bureau, Health Care Financing Administration.

[1] National Center for Health Statistics, "The National Nursing Home Survey: 1977 Summary for the United States," "Vital and Health Statistics," series 13, No. 43, Hyattsville, Md., July 1979.

[2] Public Law 92-603, section 246.

[3] 42 CFR 405, subpart K.

[4] 42 CFR 442, subpart E.

[5] These data on nursing homes come from National Center for Health Statistics, "The National Nursing Home Survey."

Nursing homes are operated largely (94.5 percent) by privately owned organizations. Most of these (81.3 percent) are operated for profit. Although most homes are individually owned businesses, multi-facility operations are an important share of the market (28.1 percent of all facilities).

Although both Medicare and Medicaid covers services in skilled nursing facilities, the two programs define coverage differently and finance different types of nursing home care. These and other differences between the Medicare and Medicaid programs are described in Chapter II.

Congress designed the Medicare skilled nursing home benefit as an alternative to extended hospital stays. The benefit provides elderly and disabled beneficiaries with a maximium 100 days of intensive nursing or rehabilitation care, following a hospital stay. In practice, Medicare-covered stays average only about 28 days.[6] Most Medicare patients obtain short-term coverage for nursing or rehabilitation services delivered on a daily basis.

In contrast, Medicaid, which covers health care for the poor, finances relatively long nursing home stays in skilled and intermediate care facilities. In many states, Medicaid patients receive relatively long-term skilled benefits. Medicaid skilled benefits are not limited to 100 days and do not require a prior hospital stay. More important in explaining longer stays is the fact that many Medicaid-covered SNF patients are receiving general rather than specific skilled nursing services (including supervision of aide-delivered assistance in activities of daily living) or have mental or physical problems that make them difficult for nursing homes to manage.

C. Evidence of access problems

Strong evidence exists that Medicare beneficiaries and Medicare eligibles face difficulties in obtaining covered nursing home care. Chapter III reviews direct and indirect evidence of access problems. Direct evidence comes from reported backups of patients waiting in hospitals for a nursing home bed to become available. Indirect evidence of Medicare problems comes from declines in Medicare utilization through time and the substantial variation in utilization across states. Analysis of Medicaid utilization also demonstrates that there is a shortage of beds for Medicaid eligibles seeking nursing home care.

Hospital backups.—The most direct evidence of access problems comes from reports that patients remain in hospitals beyond the appropriate point of discharge, awaiting placement in a nursing home bed. Estimates of such "administratively necessary days" range from 250,000 to 2,3 million hospital days for a three month period. Data on administratively necessary days are not sufficiently precise to distinguish between Medicare and Medicaid skilled-level patients or between Medicaid skilled-level and Medicaid-intermediate level patients. Nor do they allow measurement of the extent of the problem in different geographic areas.

According to hospital discharge planners, other health professionals, and ombudsmen for the elderly, the ease or difficulty of placement varies considerably from place to place and depends heavily on a narrowly defined local market. Where difficulties arise, they can reflect small numbers of appropriately licensed or program-certified beds or the unwillingness of nursing homes to take certain types of patients. In some areas homes willing to accept Medicare patients are particularly hard to find; in other areas, access for Medicaid patients is the major problem.

Utilization patterns.—Further evidence of access problems for Medicare patients is the decline in Medicare use of nursing home beds, independent of any apparent decline in the expected need for care. Medicare-covered nursing home days per thousand enrollees dropped over seventeen percent between 1977 and 1979, with twenty-seven states experiencing declines of more than ten percent. Covered days also vary dramatically (more than tenfold) across states. These differences cannot be explained by readily observable differences in population characteristics.

Evidence of access problems for Medicaid patients comes from earlier research showing there are insufficient nursing home beds available to serve people eligible for Medicaid who are seeking nursing home care. Differences in states' classification criteria make it impossible to distinguish availability problems for skilled or intermediate level beds. Furthermore, the research identifies a shortage of beds relative only to persons seeking care, not for persons objectively identified as needing care.

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[6] Charles Helbing, "Medicare: Use of Skilled Nursing Facilities, 1976-1977." Health Care Financing Notes, Health Care Financing Administration, HEW Publication No. (HCFA) 03021, p. 2. Data are for 1977.

D. Reasons for medicaid access problems

Understanding access problems must begin with Medicaid. State Medicaid programs are the largest purchasers of nursing home care, providing approximately one-half of nursing homes' revenues. About sixty percent of nursing home residents are supported by Medicaid, either in total or as a supplement to their limited incomes. Medicaid sets the rate paid by patients who receive any medicaid support.

Medicaid policies, therefore, largely shape the character of the nursing home market—where homes locate, how many beds they supply, what type of care they provide (skilled or intermediate). Chapter IV reviews Medicaid policies and explains the access problems that result.

Medicaid access problems do not reflect nursing homes' unwillingness to participate in the Medicaid program. Less than four percent of skilled facilities participate in Medicare and not Medicaid. Furthermore, the Medicaid access problem is not specific to the skilled or intermediate level. The shortage of beds affects all types of Medicaid eligibles wanting to enter nursing homes and impinges most on patients with the greatest care needs within a given level of care, skilled or intermediate.

As explained in Chapter IV, the Medicaid shortage results primarily from state efforts to limit Medicaid expenditures, 34.9 percent of which went to nursing homes (skilled and intermediate) in 1979. States have attempted to control Medicaid spending on nursing homes primarily by limiting the number of nursing home beds. Both payment policies and certificate-of-need regulations have been used to control the bed supply and thereby control Medicaid use. Because private market rates are higher than what Medicaid programs pay, homes prefer to fill beds first with private patients, allocating the remaining beds to Medicaid patients.

Equity considerations make it difficult for states to deny Medicaid eligibility tp persons who might need nursing home care but could not afford it. It is also difficult to limit nursing home use only to Medicaid-eligibles with the greatest need for care. The result of broad Medicaid eligibility and constrained bed supply is more people seeking care than there are beds available.

In these circumstances, nursing home administrators can choose what intensity of care to offer and what types of Medicaid patients to serve. The skilled and intermediate patients needing the least care are generally more attractive to nursing homes than sicker patients, as reimbursement rates do not distinguish among varying care requirements and hence varying costs within each skill level. As a result, the people with the greatest need for nursing home care have the greatest difficulty finding beds. These problems might be reduced if Medicaid programs varied rates to reflect differences in patients' care needs.

E. Reasons for medicare access problems

Medicare patients are dependent for short-term, intensive care on a nursing home industry that is oriented toward long-stay Medicaid patients. Chapter V analyzes the access problems Medicare patients face. Their access problems have four sources:

Absence of SNF beds.—In some areas Medicaid and private demand are insufficient to support the operation of skilled nursing facilities. Hence, none exist. As reported in Chapter V, over half the elderly population in five states (Iowa, Louisiana, Nebraska, New Mexico, and Oklahoma) live in counties without SNFs; in another eight states, more than a quarter of the elderly are in similar circumstances. The problem is more severe for elderly in rural areas. The proportion of elderly living in rural areas without SNFs exceeds 50 percent in eleven states and is greater than 80 percent in four (Iowa, Louisiana, New Mexico, and Oklahoma).

Hospitals may compensate for the absence of skilled facilities. There are fewer areas which do not have either hospitals or skilled facilities. Furthermore, many hospitals presently have excess capacity. Counting only hospitals that had less than 90 percent occupancy in 1979, only 6 percent of the elderly do not live in a county with available hospital beds. This represents less than one-half the number that reside in counties without skilled facilities.

Reluctance of SNFs to participate in medicare.—Nationwide, a full third of skilled facilities that participate in Medicaid do not participate in Medicare. Participation rates vary from only 3.5 percent in Arkansas to full participation in sixteen states. Chapter V identifies the reasons that nursing homes are reluctant to participate in Medicare.

Nursing homes' reluctance to participate in Medicare when they participate in Medicaid reflect differences between Medicare and Medicaid in the enforcement of certification standards, the care needs of patients, and payment practices. Although the law establishes uniform certification standards for skilled facilities wishing to participate in Medicare and Medicaid, regional offices and nursing homes report dis-

crepancies in the application of standards by the two programs. Medicare had reportedly been more rigorous in its overall enforcement of health and safety requirements and, in some regions, its interpretation of staffing requirements. In these circumstances, homes may avoid Medicare participation because they are unwilling or unable to meet Medicare standards.

Independent of standards enforcement, homes may choose not to seek Medicare certification because they do not provide the intensity of care Medicare patients require. Differences in Medicaid criteria for skilled level coverage, lower rates, and Medicaid's exclusion (in some states) of rehabilitation services covered by Medicare would all contribute to lower staffing levels for Medicaid than for Medicare. Homes choosing to concentrate on the Medicaid market might not consider themselves able to serve Medicare patients.

Data show that homes participating in Medicare as well as Medicaid in fact have higher ratios of staff to beds than nursing homes that participate in Medicaid only. These staffing differences undoubtedly reflect nursing homes' decisions to orient their services to a particular market, as well as the enforcement of certification standards.

Medicare's reimbursement policies also discourage some homes from participating. Medicare pays nursing homes the "reasonable costs" of care, calculated and audited retrospectively. For routine services, Medicare payments are the home's average daily cost for all patients times the number of Medicare patient days. Where Medicare patients require more than an average amount of care, payment will not cover costs incurred. (This problem is reduced for homes certifying only a "distinct part" of their beds for Medicare. But that option imposes accounting costs that exceed potential revenue gains for some homes.) Furthermore, Medicare participation imposes accounting requirements and leads to retrospective "disallowances" (reductions in expected payment) that are not a part of most Medicaid programs' prospective payment systems. Given these aspects of Medicare policies, low cost, Medicaid-oriented homes would gain little from Medicare participation. Homes might be more willing to participate if Medicare allowed homes to accept payment at Medicaid rates or adopted its own prospective payment system.

Patient selection.—Medicare patients may have difficulty obtaining a bed even in facilities that participate in Medicare. These access problems have several causes. First, high occupancy rates and long waiting lists may limit the availability of beds at the time a Medicare patient is ready to leave the hospital. By the time a bed becomes available, the patient may have recovered enough to no longer qualify for Medicare benefits. Second, nursing homes serving Medicaid patients who need relatively little skilled care may consider themselves insufficiently staffed to serve some or all Medicare patients, even if the homes meet Medicare certification requirements. Or, given the high demand for their beds, they may prefer to serve patients who need less care and therefore generate higher profits or net revenues.

Nursing homes might be more willing to serve Medicare patients if payment rates varied with patients' care needs. Even these changes, however, are unlikely to affect nursing homes' preferences for private-pay patients, who provide homes greater net revenues.

Benefit administration.—Variation in receipt of Medicare benefits from place to place also reflects differences in Medicare intermediaries' interpretation of some of Medicare's coverage guidelines. Except for patients receiving clearcut and specific skilled nursing or therapeutic procedures on a daily basis, a patient's appropriateness for Medicare coverage is a matter of subjective judgment. Coverage guidelines require reviewers to assess patients' "restoration potential," "instability," and the probability of medical risk if delivery of unskilled services is not supervised by skilled personnel. As described in Chapter V, an Urban Institute study found that claims reviewers interpret coverage criteria very differently, and, as a result, award very different benefits. This variation in benefits is compounded by differences in intermediaries' review procedures. The overall result is that some beneficiaries receive more and some less nursing home coverage than the Medicare rules intend.

Medicare benefits are also limited by administrative practices that encourage some homes to bill certain patients directly or bill Medicaid even if they could potentially qualify for Medicare coverage. Medicare determines coverage retroactively, makes coverage for other than clearly-defined procedures contingent upon observed changes in a patient's condition, and extends coverage for relatively short periods. Furthermore, Medicare evaluates the appropriateness of nursing homes' claim submissions, and penalizes homes for submitting claims that are ultimately denied. No such risks accompany admission of private patients, for whom financial arrangements are often completed in advance of care. Medicaid programs determine coverage in advance (placing no responsibility on homes) and cover relatively long stays,

independent of changes in a patient's condition. Rather than risk a potentially costly mistake on questionable cases, nursing homes may prefer to submit claims to Medicaid—where coverage is predictable and long-term—than to Medicare.

As discussed in Chapter V, more equal access to Medicare benefits might be achieved by reducing the number of intermediaries centralizing oversight of their coverage decisions, and replacing retrospective with prospective coverage determinations.

F. Mandatory Dual Participation

As Congress directed, this report assesses the desirability and feasibility of one specific measure to reduce access problems: requiring all nursing homes that participate in Medicaid to participate in Medicare, and vice versa. This policy would potentially add many more skilled beds to Medicare (217,538) than to Medicaid (18,243). In almost half the states with few Medicare-certified beds, the policy would have a negligible impact. Even when the policy increased the number of Medicare-certified beds, it would not ameliorate Medicare patients' access problems arising from the excess of overall demand for nursing home care over existing supply and nursing homes' orientation toward longer stay and less costly patients. In addition, under existing payment rules, Medicare would not pay the full cost of the operating requirements mandatory participation would impose. Costs would be shifted to Medicaid and private patients.

Even with no change in access, requiring Medicaid homes to participate in Medicare would increase billings to Medicare, as states enforced provisions making Medicaid the payer of last resort. As a result, Medicare liabilities would increase, unless Medicare maintained thorough claims review against its specific coverage criteria.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. I have no questions. I want to thank you for your statement. Your group always makes a great presentation and it has been very helpful to us.

Chairman JACOBS. I am still a little puzzled by your comparison of the $4 billion and $12 billion. Is the $4 billion the actual number?

Mr. MACDONALD. That is what we have been told by the Hill-Burton program people that they spent.

Chairman JACOBS. So those are in uninflated dollars, the $4 billion?

Mr. MACDONALD. Yes.

Chairman JACOBS. The $12 billion, is that adjusted back to that time?

Mr. MACDONALD. No, no. That is from 1981 to 1990.

Chairman JACOBS. So it is really oranges and apples here, isn't it?

Mr. MACDONALD. Correct, in terms of inflated dollars, dollars that we are going to have to be committing in the future.

Chairman JACOBS. If you adjusted the $12 billion, it might look more like the $4 billion or even less?

Mr. MACDONALD. That is right.

Chairman JACOBS. Thank you very much.

Mr. MACDONALD. I think that in terms of reimbursement, capital costs are a very real problem that through the medicare program and medicaid program we are all going to have to be addressing.

Chairman JACOBS. If it is $1.50, it is a problem for me. I just wanted to get that straight for the record.

This concludes the hearings. We thank all the witnesses who contributed to the record.

The committee stands adjourned.

[Whereupon, at 12:10 p.m. the subcommittee adjourned.]

[The following was submitted for the record:]

STATEMENT OF PETER D. ROSENSTEIN, EXECUTIVE DIRECTOR, THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

I am pleased to submit a statement for the record on behalf of the American Academy of Physician Assistants concerning possible changes in Medicare reimbursement policies that would encourage additional participation by skilled nursing facilities (SNFs).

The Academy is the professional society for the physician assistant profession. Physician assistants (PAs) are health care practitioners who serve under the direction and supervision of licensed physicians. They are educated and trained in accredited programs at more than 50 American medical schools and colleges and universities affiliated with teaching hospitals. As a result of their education, PAs are qualified to perform a minimum of 70 percent of the clinical procedures carried out by physicians in general practice. Program graduates sit for a national certifying examination which assures that they have achieved certain standards of proficiency in primary health care delivery. PAs may be found working in all types of practice settings, including hospitals, nursing homes, health maintenance organizations, clinics and private practices, both general and specialty.

The federal government has supported development of the PA profession by including funds for PA educational assistance in every health manpower bill since 1971. In 1977 this Committee produced the Rural Health Clinic Services Act (Public Law 95–210) which supports utilization of physician assistants and nurse practitioners.

However, there is currently a fundamental contradiction in federal policy. On the one hand, the federal government has supported the PA concept by financing PA training programs and by funding delivery systems in underserved areas which utilize PAs. On the other hand, the federal Medicare program (under Part B) does not provide reimbursement for PA services in any setting except a certified rural health clinic.

The Academy would like to recommend a change in Medicare policy to cover PA services in skilled nursing facilities. Such a change would benefit all concerned by increasing employment opportunities for PAs, providing more accessible qualified care for patients, and, in the long run, lowering costs for SNFs and the public sector.

Skilled nursing facility and intermediate care facility regulations require that patients/residents be visited by their physicians at regularly scheduled intervals. The purpose of this requirement is to ensure the direct involvement of physicians in the care of the patient.

Experience has shown that physicians as a whole have been reluctant to visit their patients in long term care facilities, which in turn has resulted in inadequate supervision of the care of the patient.

PAs could assume the responsibility of the attending physician in visiting and caring for the patient if properly supervised by the sponsoring physician. In fact, under the Budget Reconciliation Act (Public Law 97–35), language was included allowing PAs and nurse practitioners to recertify the need for in-patient care in SNFs and ICFs under state Medicaid plans.

Skilled nursing facility and intermediate care facility regulations require that a physical examination be conducted of each patient immediately following admission unless such examination was performed within a certain number of days prior to admission. This examination is usually performed by a physician. However, it could be performed by a PA as a delegated function under supervision of the sponsoring physician.

SNF and ICF regulations require that physician services be available in the event of an emergency. PAs could be utilized for rendering emergency services under properly established protocols in the event the attending physician is not available.

These are but a few examples of the medical responsibilites that could easily be assumed by qualified PAs.

The Academy recommends that SNFs be encourged to employ PAs whose services would then be reimbursable under Medicare and who would be supervised by physicians either in the local community or on the staff of the nursing facility. Alternatively physicians in the community could hire PAs who would make daily visits to the facility under a predetermined arrangement. Such arrangements would vary depending on the supervision and delegation of medical services language contained in state laws and regulations.

We make this recommendation based on the knowledge that PAs under proper supervision can perform 70 to 80 percent of the physician's workload in a primary care setting. It should be noted that proper supervision does not necessarily mean

on-site, "over the shoulder" supervision, but rather implies close communication between PA and physician and regular consultation and review.

The elderly population in this country has risen from 9.7 percent of the population in 1970 to 11.1 percent in 1981, and it is projected to reach an unprecedented 20.4 percent by the year 2030. This growth is significant because the elderly are hospitalized twice as much and visit doctors more than 1.3 times as often as the population as a whole.

The types of diseases found most frequently among the elderly, such as arthritis, hypertension, diabetes, emphysema and heart disease, are generally chronic, requiring constant care.

According to a study conducted by Louise B. Russell of The Brookings Institution, if current demographic and health care trends continue, almost two and one-half times as many people will be in nursing homes by the year 2040 as were in nursing homes in the year 1975. There will also be almost one-third more days spent in the hospital.

PAs are trained in primary care. They are, therefore, skilled in handling the needs of SNF patients and can be very effective in the management of chronic diseases and in preventing repeated and expensive hospital admissions.

The 1981 White House Conference on Aging approved a resolution calling for Congress to amend Title XVIII of the Social Security Act to reimburse for PA and nurse practitioner services in nursing homes.

The American Academy of Physician Assistants endorses this recommendation and would be pleased to work with the Committee to develop an equitable and cost effective method of reimbursement for PA services under Medicare. We believe that PAs can make a substantial contribution toward improving medical services in nursing facilities.

Statement of Alan M. Dinsmore, Specialist in Governmental Relations, American Foundation for the Blind

The American Foundation for the Blind welcomes this opportunity to assist the Subcommittee on Health in its consideration of issues relating to the revision of Medicare coverage and reimbursement of skilled nursing facility services. We wish to specifically address the issue of the deletion of the 3 day prior hospitalization requirement and the possible adoption of some form of prospective reimbursement.

Our interest in these issues is related to the increasing numbers of older blind and vision-impaired Medicare beneficiaries who will, at one time or another, be hospitalized and may also be admitted for a period to a skilled nursing facility.

Several witnesses have provided information to this Subcommittee relating to the shortage of available skilled nursing facility beds along with the tightening of eligibility and retroactive denial of benefits for Medicare patients supposedly eligible for skilled nursing facility care.

Matching these statements to our own projections of the need to serve an increasing number of older blind and vision impaired persons makes us doubt that the present coverage and reimbursement system will respond effectively to this situation.

We wish to emphasize that blindness alone does not create a need for institutionalization. However, blindness or severe vision impairment coupled with other handicapping conditions often results in skilled nursing facility placement after a hospital acute care episode.

VISUAL IMPAIRMENTS IN INSTITUTIONALIZED (NURSING HOME) ELDERLY POPULATION

The 1977 National Nursing Home Survey of the National Center for Health Statistics estimated that about 5 percent of all elderly people reside in nursing homes at any given time. That study, also reported, that, based on observations of nursing home staff, about 3 percent of the residents were unable to see and another 26 percent were partially or severely visually impaired, giving a total of about 344,000 nursing home residents who were visually impaired.

Severe visual impairment is defined as inability to see or to read ordinary newspaper print, even using glasses.

Another way of viewing this situation is to compare the institutional and non-institutional severely impaired elderly population. Measured by the 1977 Health Interview Survey of the National Center for Health Statistics, the non-institutional severely vision impaired age 65 and older population comprises about 990,000 persons.

Keeping in mind that the Health Interview Survey and the Nursing Home Survey use different measures of visual loss, we believe that adding the figures from the

two studies gives a valid rough estimate of about 1,334,000 seriously visually impaired elderly persons, of whom about 25 percent are in nursing homes.

Keeping in mind the limitations of these data gathering instruments and the difficulty in separating skilled nursing facility and intermediate care facility populations in the samples, we are still persuaded that rates of severe vision impairment among the skilled nursing facility population are such that we must focus attention on the availability of SNF beds, reimbursement systems, and quality of care.

Regarding quality of care, we do accept the Subcommittee's instruction that conditions of participation are not within the purview of this hearing. However, we do wish to emphasize our belief that the manner in which a facility is paid is one of the factors influencing quality of care. For that reason, we will address this issue under our suggestions regarding prospective reimbursement for SNFs.

3-DAY PRIOR HOSPITALIZATION REQUIREMENT

Linkage of coverage for services in a skilled nursing facility to the three day prior hospitalization requirement has been coupled with the issue of maintenance of the acute care emphasis of the Medicare system and the necessity of some form of control over possible inducement to over-utilize skilled nursing facilities absent this requirement.

We believe that the Subcommittee's review of this requirement is timely and we urge your favorable consideration of its elimination.

We take this position for the following reasons: First, compliance with the requirement may well mean over-utilization of far more costly acute care beds; second, the requirement ill serves the Medicare eligible population's need for skilled rehabilitation services; third, the requirement ignores the emergence of the skilled nursing facility as an important link in the long term care system.

COSTLY ACUTE CARE BED UTILIZATION

According to the Health Care Financing Administration report on 1980 National Health Expenditures, hospital care accounted for just over 40 percent of total health care spending in 1980. The same report notes that:

In fiscal year 1980, Medicare payments per short-stay inpatient day of care increased over 12 percent, about the same rate as community hospital expenses per inpatient day. However, total Medicare hospital outlays grew faster than community hospital expenses. Days of care provided to persons over age 65 and older increased faster than days of care provided to persons under age 65.

While these increases are certainly not entirely attributable to use of the three day prior hospitalization requirement as a qualifier for SNF admission, we believe that close scrutiny should be given to the continued use of what appears to be a very expensive gate keeping mechanism.

REHABILITATION NEEDS OF THE MEDICARE POPULATION

The question of whether or not the three day prior hospitalization requirement also suits the rehabilitation needs of this population should be examined.

First of all, while we do understand that expansion of covered rehabilitation services under Medicare cannot be considered at this time, we do wish to point out that orientation and mobility services, rehabilitation teaching services, and other services designed to restore a patient to maximum functional independence after loss of sight are not covered.

Similar basic rehabilitation services, such as physical therapy or speech therapy are covered for persons with other disabling conditions.

But more to the point of this hearing, a substantial amount of evidence is accumulating which indicates that even basic coverages are often denied by more restrictive applications of regulations relating to certification of need for SNF admission.

The point we wish to make is that the three day prior hospitalization requirement appears to be not only a very expensive gate keeping mechanism but also that, given an apparent necessity to draw even more restrictive lines on qualification for SNF coverage, it's a gate keeper that doesn't work.

THE SNF, AN IMPORTANT LINK IN THE LONG-TERM CARE SYSTEM

Time and time again the debate on long term care has focused on the multiple impairments of the nursing home population and the fluctuating nature of the diseases causing these impairments. Data from the 1977 Nursing Home Survey show

that transfer from intermediate care facilities to skilled nursing facilities and back is not uncommon.

For example, and older blind diabetic may go through several episodes of fluctuating vision related to Diabetic Retinopathy, a circulatory abnormality in the blood vessels of the eye which usually affects the retina. This, along with other complications of Diabetes often leads to the need for hospital care and skilled supervision of recovery.

However, if the blind diabetic is a private pay resident of an intermediate care facility who, at some point needs skilled care, we see only inconvenience and additional health hazards related to the need for a hospital stay in order to qualify for Medicare coverage in a SNF.

Similarly, we have long felt that Medicare's waiver of the three day requirement with respect to readmission to a SNF within 14 days of termination of a previously certified SNF stay makes curious assumptions regarding acute care episodes and their relation to the ongoing need for daily skilled care.

Why, for example, on the 16th day after discharge, must we now assume that the whole process has to be recertified?

Such convoluted requirements often result in so-called convenience stays in high cost acute care beds or, worse, may delay admission to a more appropriate and certainly less costly facility.

PROSPECTIVE REIMBURSEMENT

Nationwide application of a prospective reimbursement scheme for Medicare skilled nursing facilities has generated a wide-ranging debate regarding the basis for determining rates of payment per unit of service, the amount of profit to be kept by the provider, and mechanisms for making rate adjustments to name just a few elements.

The question that the Subcommittee poses, namely whether or not such a system would encourage additional Medicare participation by skilled nursing facilities is a difficult one.

We think prospective reimbursement does have merit. However, given the widely varying characteristics of skilled nursing facilities, we question whether a nationwide standard can be developed which would encourage more SNF participation in Medicare.

Further, absent more uniforms standards of intermediary performance, a reduction in paperwork, and more reliable regulation of identified skilled nursing care coverages, we see little chance that any modification of payments would attract new providers and insure the coverage which Medicare beneficiaries have a right to expect.

We urge the Subcommittee to examine the potential of Section 1861(v)(1)(E) of the Social Security Act which provides that reimbursement methods which the Secretary finds acceptable for a state's Title XIX program can be used as a standard for Medicare skilled nursing facility reimbursement in that state. It is our understanding that the Department of Health and Human Services has never issued regulations to implement this section.

In general, the nursing home industry supports prospective reimbursement. If some form of a prospective system is to be considered, we urge the Subcommittee to closely examine the merit of a state by state approach. Further, we think that such an approach should be tied to some form of retroactive adjustment for overspending related to the provision of higher quality care.

The elimination of the three day prior hospitalization requirement and a close examination of prospective reimbursement, in tandem with better intermediary performance, more reliable standards for reimbursement, and use of the system to encourage better standards of care are reachable goals. We appreciate the Subcommittee's interest and are eager to assist in drafting such revisions.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association takes this opportunity to submit this statement in connection with the February 2, 1982 hearing on Medicare Skilled Nursing Facility Coverage. Our comments will address two distinct issues relating to skilled nursing coverage under Medicare: (1) the three-day prior hospitalization requirement that a beneficiary must meet to be eligible to receive Medicare coverage for extended care facilities services; and (2) the definition of "spell of illness" as it relates to Medicare coverage for hospital and extended care services.

Three-day prior hospitalization requirement

The three-day prior hospitalization requirement that a beneficiary must fulfill to be eligible to receive "post-hospital extended care services" under Medicare has been an element of the program since its inception in 1965. The American Medical Association's House of Delegates, at its 1965 Clinical Convention called for the elimination of this prior hospitalization requirement. Since 1965, the AMA has repeatedly called for the elimination of the prior hospitalization requirement. In December 1981 the AMA again emphasized the desirability of repeal of this requirement by endorsing H.R. 4227, a bill to remove the three-day prior hospitalization requirement for coverage of extended care services. In addition to endorsing H.R. 4227, the American Medical Assocation has developed draft legislation designed to have the same effect by eliminating this requirement from the Medicare program. For the Committee's information, a copy of this draft legislation is attached to this statement.

Previous AMA policy statements calling for the elimination of the prior hospitalization requirement have pointed to increased costs, unnecessary inconvenience, and unnecessary hospital bed occupany as reasons to eliminate this requirement in the law. These three reasons each present an independent rationale for removal of the three-day prior hospitalization requirement. In effect, our policy is based on the premise that a patient should be in the most appropriate setting where the needed level of care can be provided. Under existing law, patients are often foreclosed from seeking such appropriate care by the fact that the Medicare program either denies coverage for extended care facility services or forces the patient into more costly hospital impatient care.

We recognize that when the extended care service benefit was written into the law in 1965, it was considered a mechanism to prevent inappropriate hospital utilization and to encourage more appropriate nursing facility care. In describing this provision, the Senate Finance Committee Report No. 404, June 30, 1965, stated that:

"Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients."

While the framers of the Medicare program did envision situations where an individual could go home from a hospital and subsequently enter a skilled nursing facility or situations where extended care services could be interrupted without hospitalization preceding readmission, they did not establish conditions where the individual could go directly into an extended care facility. This is a defect that should be corrected.

We recognize a concern that without the prior hospitalization requirement there may be an increased use of extended care services. However, under current law, there is an inappropriate incentive toward hospitalization, even though an extended care facility may present an appropriate source of care for a particular patient. In our view, elimination of the prior hospitalization requirement will provide a more efficient utilization of program resources.

Even with the elimination of the prior hospitalization requirement, the law and regulations would still work to assure proper utilization. Initially, there must be a physician certification of need for care to assure appropriate eligibility for facility services. In addition, the Medicare Conditions of Participation for Skilled Nursing Facilities require that "prior to or at the time of admission, patient information which includes current medical findings, diagnoses, and orders from a physician for immediate care of the patient" must be available. The Conditions further require that "the facility has a policy that the health care of every patient must be under the supervision of a physician who, based on a medical evaluation of the patient's immediate and long-term needs, prescribes a planned regiment of total patient care." (42 C.F.R. 405.1123) The regulation also requires the facility to carry out a plan of utilization review. (42 C.F.R. 405.1137)

Mr. Chairman, elimination of the prior hospitalization requirement would have significant benefits. It would eliminate unnecessary utilization of costly in-patient hospital care. In addition to this, and of greater importance, it would encourage the patient to seek care in the most appropriate setting for his or her particular needs. The AMA strongly endorses elimination of the prior hospitalization requirement.

SPELL OF ILLNESS

Under existing law, an individual is entitled to have Medicare coverage for up to 100 days of extended care services in each "spell of illness," as defined by Section 1861(a) of the Social Security Act. In situations where a patient has utilized all of

the available in-patient hospital and extended care benefits during a spell of illness, there must be a minimum 60-day period during which the beneficiary is neither an in-patient of a hospital nor an in-patient of a skilled nursing facility for "spell of illness" benefits to reaccrue. This requirement creates the situation where an individual may use all of his or her allowable benefits, remain in an institution, while being financially responsible for his or her own care for a 60-day period or longer. In such a case, the beneficiary is not eligible to reaccrue institutional benefits, even though he or she has not received program benefits during that period.

By way of contrast, where a patient had not been an in-patient in a hospital or an extended care facility for 60 days (for instance, where he or she has an alternative of returning home), that patient would be eligible to reaccrue benefits.

We recommend that this inequitable situation be corrected. In making this change, it must be remembered that certification procedures to assure a need for care would still be applicable for such situations where a new spell of illness would accrue.

Mr. Chairman, the AMA stands ready to work with you, and the Subcommittee on Health and its staff in making the Medicare program responsive to the health care needs of the elderly. We believe that the two changes we suggest would be a step in this direction.

EXTENDED CARE SERVICES AMENDMENTS

This legislation would delete the Medicare requirement that a three day period of hospitalization must occur prior to a patient's admission to a skilled nursing facility for purposes of reimbursement. (The prior hospitalization requirement for readmission to a skilled nursing facility was liberalized in the Omnibus Reconciliation Act of 1980; however, the three day prior hospitalization requirement was left intact.)

A BILL To amend the Social Security Act to delete the three day prior hospitalization requirement for beneficiary coverage under Medicare of Skilled Nursing Facility Services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

FINDINGS AND DECLARATION OF PURPOSE

SECTION 1(a) The Congress finds—

(1) That payment under the Medicare program for extended care services requires that the beneficiary must have been an inpatient of a hospital for at least three consecutive calendar days and have been transferred to a participating skilled nursing facility from a hospital;

(2) That this requirement often imposes unnecessary expense through the requirement that a patient be hospitalized prior to being admitted to a skilled nursing facility; or prevents patients from receiving Medicare coverage for necessary extended care services when prior hospitalization cannot be justified:

BLUE CROSS OF OREGON,
Portland, Oreg., February 9, 1982.

ELIMINATION OF THE 3-DAY HOSPITALIZATION REQUIREMENT DEMONSTRATION PROJECT

Since the creation of the 'Skilled Nursing Facility' through the Extended Care Provisions of the Medicare Act in 1965, the efficiacy of the restrictions placed upon the Medicare beneficiary for admission to a SNF has been debated in terms of beneficiary hardship and Medicare program cost effectiveness. The required three day hospital stay and other requirements for SNF admission were logical safeguards in 1965 to ensure continuity of medically necessary care in a less costly facility. Until the SNF Waiver Demonstrations were established in Oregon and Massachusetts in 1977, little was done to evaluate the possible impact of removing prior stay requirements on utilization, costs to the program, and ability of the SNF to function as a primary care provider.

While Blue Cross of Oregon cannot officially assume an evaluator role in the SNF Waiver Demonstration, it can provide observations and perceptions about the impact of the project in the Oregon environment.

Utilization

Even though the Demonstration Project created an opportunity for more admissions to the SNF and extensive educational efforts were directed to the health care community concerning the experiment, admissions under conditions of the waiver began and continued at a modest rate [7.43 percent of SNF Medicare admissions]. During the year 1980, admissions under the waiver were more numerous and consistent on a month-to-month basis. This, however, is most likely due to increased awareness and skill in identifying patients appropriate for admission under the Waiver and the familiarity of SNF staff and PSRO reviewers with admitting procedures and submission of claims for this category of patient. It is interesting to note that predictions from the HCFA Office of the Actuary indicated that removal of prior stay requirements would result in a 'waiver' admission rate of 25 percent, projected nationally.

The twenty-eight SNF's participating in the demonstration represented a total of 1,228 Medicare certified beds available in the State of Oregon with 39 percent of the total located in Multnomah County [Portland metropolitan area]. Central and South-Central Oregon were the only areas in Oregon without any SNF participating in the experiment; admissions under the waiver totaled 648 for the thirty-three months of the project. The ten Multnomah County facilities accounted for 29 percent of waiver patient admissions. Scarcity of certified beds, not of potential patients, is the reason cited by these facilities as limiting waiver admissions. This was not perceived as a major problem in most areas outside Multnomah County. However, limitations on Medicare reimbursement was the cause stated by three hospital-based SNF's who decertified from Medicare during the course of the project. A further limiting factor to admissions under the waiver [and to Medicare admissions in general] was the medical necessity criteria for skilled care which was imposed uniformly by the Intermediary and the PSRO's for a patient admitted with the expectation of Medicare coverage.

Other influences which were perceived early as potential problem areas in utilization produced little or no negative impact. Some of these were: lack of awareness and support of the project by SNF's, hospitals, physicians; effects of PSRO review implementation; reluctance or discomfort on the part of SNF's to accept patients without hospital stays; reluctance of physicians to bypass the traditional hospital stay.

Additional utilization factors including length of stay, diagnoses, sources of waiver patients, etc. are displayed on the attached Data Summary.

Costs to the medicare program

On the basis of our data, interviews with Oregon SNF's, and study of SNF operations and pattern practices, Abt Associates' evaluation indicates that the program is cost effective in the State of Oregon. This is based on survey results from the participating SNF's which show that, without the waiver, 60 to 70 percent of waiver patients would have been admitted to the hospital. This rationale is impressive in terms of saved hospital days.

However, for those patients already residing in the SNF and who became eligible for Medicare coverage, facilities indicated that only about one-half would actually be transferred to a hospital. SNF professionals were admittedly reluctant to transfer patients, particularly terminal patients, when care can be adequately provided within the SNF. This attitude is based on studies of 'transfer trauma' as well as the desires of beneficiaries and their families. Before the waiver project, facilities had often cared for patients in lieu of hospital transfer and without Medicare coverage. Care was paid for in these cases by private sources; sometimes not at all. Therefore, it appears that this practice pattern became a cost to the Program during the waiver project.

The SNF as a primary care facility

The concern of HCFA in the original RFP for the project was that the SNF might fancy itself as a "pseudo hospital" and attempt to care for seriously ill patients, that it would have difficulty in making level of care decisions about patients without a hospital stay, that quality of care might suffer without the medical assessment on the hospital transfer form.

As a result of reviewing each and every claim for patients admitted under terms of the waiver, analyzing medical records, making coverage decisions, visiting and communicating with the involved SNF's, the project staff at Blue Cross of Oregon feels that data so collected supports the concept of the SNF as a capable primary care facility. Thirty-eight percent of waiver patients were admitted from home and generally did not present the SNF with problems in assessment of needs, level of

care or continuing management. Cases of non-covered care were found but denial rates followed the SNF's track records for denial rates involving non-waiver patients who met prior stay requirements. The death rate for waiver patients was high [29 percent]. Most of these patients, however, were already classified as terminal. Feedback from facilities indicates that about one-half of these patients would have been transferred to the hospital if the waiver project were not in place. SNF's also report that beneficiaries and their families were grateful for the opportunity to keep the patient at the SNF for terminal care.

Reports from the evaluator support the perception that SNF care delivered in Oregon, with or without a prior hospital stay, is of high quality [rated good to excellent].

Blue Cross of Oregon, in its role as Demonstration Project Contractor, has been very sensitive to the requirements of the negotiated contract. We feel that we have not only complied with its specifications but have gone the "extra mile" to ensure the best possible quality and quantity of data and the most productive environment for the conduct of the project. This has been possible because of the diligence of the project staff, continuing corporate support, and encouragement and the positive reaction of the health care community—particularly the participating Skilled Nursing Facilities. Blue Cross of Oregon feels that the temporary elimination of prior stay requirements for Skilled Nursing Facility admission has shown sufficient merit for Congressional consideration of a permanent elimination of these conditions.

Respectfully submitted,

JAMES M. BURNS,
Project Director.

Attachment.

- DATA SUMMARY -

April 1980 through December 1980

[28 Skilled Nursing Facilities]

	3-Day Waiver Patients	Non-Waiver Patients	All Patients
Admissions	648	8,070	8,718
Discharges	604	7,094	7,698
Prior Hospital LOS	N/A	17.53	17.53
SNF LOS	23.32	28.25	27.83
Interim Reimbursement	$ 504,787.06	$7,847,603.31	$8,352.390.37
DIAGNOSES: Five most frequent	1. Carcinoma 2. CVA or Stroke 3. Cardiovascular Disease 4. Respiratory Disease 5. Fractures	1. Fractured hip 2. CVA or Stroke 3. Cardiovascular Disease 4. Respiratory Disease 5. Other Fractures	
DEATHS	178	1,025	1,203

SOURCES OF ADMISSIONS	
Home	231 or 38%
Same Facility Transfer	280 or 46%
Hospital [1-2 day stay]	52 or 9%
Other Long Term Care Facility	41 or 7%

% OF ADMISSIONS TO A CERTIFIED SNF BED	7.43%	92.57%
% OF DISCHARGES FROM MEDICARE COVERED SNF CARE	8.9%	91.1%

NOTES:

1] Above data relates only to Medicare beneficiaries occupying Medicare certified beds in a participating SNF in the State of Oregon.

2] Data collection ceased on February 1, 1981.

BEST COPY AVAILABLE

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY,
DEPARTMENT OF HEALTH SERVICES,
Sacramento, Calif., February 17, 1982.

JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: The California Department of Health Services would like to offer the following comments for the printed record of the Subcommittee of Health of the Committee on Ways and Means hearing on Medicare Skilled Nursing Facility Coverage and Reimbursement.

A. The Department supports eliminating the three day prior hospital stay as a condition of Medicare skilled nursing facility (SNF) coverage, for the following reasons:

1. With the increase in medical technology, hospital lengths of stays are constantly being reduced. Many diagnostic services, and even some major surgical procedures, can be performed adequately without detaining a patient in the hospital for three days, or oftentimes as outpatient procedures.

2. The Medicare program, in encouraging shorter patient stays in acute hospitals, will save the expenditure of scarce fiscal resources currently paying for inpatient hospital care.

3. The quality of patient care can be improved by lessening patient exposure to nosocomial infections and unnecessary diagonostic procedures performed during artificially lengthened hospital stays and by encouraging less costly outpatient surgery.

B. The Department would like to see the requirement that patients need and actually receive skilled nursing or skilled rehabilitation services on a daily basis changed to a requirement that patients need to only receive skilled nursing services on a daily basis. Currently, many patients who are in need of skilled nursing services are denied Medicare SNF coverage because they cannot benefit from active rehabilitative services (e.g., patients who are comatose, patients who are respirator dependent or who need gastrostomy feedings).

Currently, if these patients are also eligible for Medicaid services, state Medicaid programs bear the costs for services denied by Medicare. This cost-shift results in expenditure of publicly generated revenues in the name of keeping intact the fiscal solvency of the Medicare program. As a minimum, if the requirement for patients needing and receiving skilled rehabilitative services is not changed, it should be standardized with regard to issues of medical necessity and length of patient coverage for SNF services. The several Medicare fiscal intermediaries apply different interpretations of medical necessity and length of coverage to the same diagnostic conditions, depending upon geographical location of the patient and the intermediary. Some norms for medical necessity and length of coverage by major diagnostic categories should be developed for general application on a nationwide basis.

C. The Department would like to offer our experience with setting SNF rates of payment for Medicaid services for the Committee's consideration.

California's Medicaid program (Medi-Cal) utilizes a prospective rate system with bedsize and geographical classifications as well as levels of care differentiated by nursing services and other health care services or programs delivered. Medi-Cal reimbursement is based upon actual costs incurred by providers during the previous year with adjustments for cost-of-living, legislative mandates and/or other legal requirements imposed upon the long term care industry.

The prospective rate system in California impels providers to be more innovative and cost efficient in their operations while maintaining acceptable minimum levels of care. From every indication, this type of reimbursement system still permits proprietary facilities to make a reasonable return on investment, as exemplified by the fact that the large nursing home chains continue to expand their operations in the state. Centralized management techniques and buying power contribute to their ability to operate profitably. In our opinion, such a system does not negatively impact upon access to treatment or length of stay since California's long term care facilities presently have an occupancy rate of 96 percent, with over 70 percent of the patients being eligible for Medi-Cal.

I hope this information proves useful to the Committee in deliberating on this controversial issue. Should you have any questions on this information, please call

me or Elisabeth H. Lyman, Deputy Director, Health Care Policy and Standards Division at (916) 445-6141.

Sincerely,

BEVERLEE A. MYERS, *Director.*

STATEMENT OF THE GRAY PANTHERS, PREPARED BY SALLY HART WILSON AND BRUCE MERLIN FRIED, NATIONAL SENIOR CITIZENS LAW CENTER

We wish to gratefully acknowledge and express our appreciation for this opportunity to submit testimony regarding Medicare coverage and reimbursement policies for skilled nursing facilities.

As the Select Committee on Aging of the House of Representatives concluded, in its report entitled "Medicare After 15 Years: Has It Become a Broken Promise to the Elderly?", beneficiaries' expectations about Medicare coverage are not being met, and in fact Medicare pays about ten percent less of their health care bill than when the program began in 1966. In our view, one of the most serious deficiencies in the Medicare program is in the area of nursing home services. This statement and the attached article will detail some of the issues in the Medicare Program that have created, fostered or perpetuated those deficiences, particularly with respect to reimbursment policies, and regulations, administrative procedures, or law that would encourage additional Medicare participation by skilled nursing facilities.

The Gray Panthers is a national organization which is made up of people of all ages, but is particularly concerned with the health problems of older persons because of their vulnerability. Most of its members are over 65 years of age and are beneficiaries of the Medicare program.

The National Senior Citizens Law Center is the national resource center for persons concerned with addressing legal needs of the elderly. It is a non-profit corporation governed by a Board of Directors drawn nationally from the field of aging. It serves attorneys, long-term care ombudsmen, paralegals and senior advocates in every state of the union who represent elderly clients and client groups. NSCLC publishes numerous materials dealing with the legal problems of the elderly and regularly publishes the NSCLC Washington Weekly newsletter and the monthly Nursing Home Law Letter.

NSCLC is funded to provide support to staff of programs funded by the Legal Services Corporation who serve the elderly poor in the United States. Accordingly, NSCLC directs it support efforts toward older Americans having low incomes.

The policies and procedures that present the greatest impediment to increased access to and availability of skilled nursing facilities for Medicare patients were identified and critiqued in a recent article, written by Sally Hart Wilson of NSCLC, entitled "Benefit Cutbacks in the Medicare Program Through Administrative Fiat Without Procedural Protections: Litigation Approaches on Behalf of Beneficiaries," 16 Gonzaga Law Review 533, (1981). A copy of this article is attached.

In particular we call the subcommittee's attention to Section III of the article, "Medicare Coverage of Nursing Home Benefits Has Been Greatly Reduced by DHEW Policies Independent of Legislative Changes." As the article point out, the pattern of decreasing Medicare nursing home coverage resulted from administratively initiated changes.

In 1972 Congress responded to earlier significant reductions in Medicare nursing home coverage by liberalizing the statute in three important ways.

The definition of covered services was expanded.

The level of care defined as covered was lowered from "extended care facility" (ECF) to "skilled nursing facility" (SNF).

The "waiver of liability" provision was adopted, designed to protect beneficiaries whose care had been retroactively determined to be "not medically necessary" by the intermediaries.

Despite Congress' effort to better meet the nursing home needs of Medicare beneficiaries, none of it came to pass. The continued reduction in Medicare nursing home coverage is attributable to several administrative policies.

The failure to issue instructions, beyond the formal regulations, to intermediaries to implement Congressional action.

The encouragement of Utilization Review Committees (URC) to use diagnostic classes of cases related to average length of stay statistics in their review of extended stays in nursing homes, thereby causing internalization of the intermediaries' restrictive views on appropriate length of stay.

The imposition of an incentive for disallowing coverage through administrative implementation of the 1972 Medicare amendments intended by Congress to liberalize coverage.

This last administrative issue is the most significant, and therefore warrants additional comment here, although it is explained in the attached law review article. As noted above, Congress, in its 1972 amendatory legislation, allowed for a "waiver of liability" for non-covered care where the individual and/or the provider, was without knowledge that such care was excluded from coverage as not "reasonable and necessary" or as "custodial care." In effect, Medicare will pay for services determined to be "custodial" or not to be "reasonable and necessary" when both the provider of services and the beneficiary did not know that payment would not be made for them. Even in cases where the provider, but not the beneficiary, knew or had reason to know that said services were not covered, the beneficiary will be indemnified against claims by the provider. This seemingly favorable language was twisted, however, so as to create an incentive to disallow coverage. An excerpt from the attached law review article most clearly identifies the administrative devices used to thwart Congressional purpose.

Regulations promulgated to carry out the mandate of this legislation (the waiver-of-liability provision) set forth criteria for determining whether there was knowledge that certain services were nonreimbursable. An individual is presumed not to have knowledge, actual or imputed, that services received were excluded from coverage unless so informed in writing by the intermediary, the provider, or the URC, or such coverage was previously denied the individual under similar circumstances. Likewise, a provider is presumed not to have actual or imputed knowledge unless so informed by the intermediary or the URC. Additionally, evidence contrary to the favorable presumption includes clear and obvious proof that items or services furnished were excluded from coverage, and proof that the provider of services failed to comply with the criteria set forth in 42 C.F.R. Section 405.195.

The source of the administratively-created incentive to disallow coverage is found in 42 C.F.R. Section 405.195. This section sets forth procedures for determining whether providers of services are liable for certain noncovered services. In addition to timely document submission, certification and recertification compliance, and patient notification of noncoverage, a skilled nursing facility must also comply with the standards for utilization review and demonstrate that it can effectively distinguish between covered and noncovered cases, the facility is required to make a decision as to coverage and to inform the intermediary of its decision. This decision is not an "initial determination" under Medicare, but rather is designed to determine whether the facility meets the established denial rate and is entitled to favorable presumptive status under the waiver of liability provisions.

Health Insurance Manual 13, the Medicare Part A Intermediary Manual, is an unpromulgated set of guidelines for insurance companies and facilities. Unfortunately, this manual fully accomplishes the distorted implementation of the law. The manual requires that, in order to obtain favorable presumptive status, a provider of services must show that the percentage of skilled nursing facility days found covered by the provider, but not covered by the intermediary, are fewer than five percent of the total number of SNF days determined covered by the provider.

Nursing homes which exceed this five percent error rate are not considered to be in good standing and thus do not receive favorable presumptive status for "waiver of liability" purposes. The effect is that they may be stuck with the bill for many days of nursing home care that otherwise would be paid for by Medicare or by the patients themselves. This creates a powerful financial incentive for nursing homes and their in-house URC's to apply "medical necessity" standards of the intermediaries in an extremely conservative manner to individual cases. Combined with the impact of retroactive coverage denials, and the short "length of stay" norms applied by the intermediaries, the nursing homes' need to preserve their good standing status in the "waiver of liability" system results in a very small portion of nursing home care being covered by the Medicare program.[1]

Beyond the use of administrative slight-of-hand to reduce nursing home coverge, the lack of procedural rights for beneficiaries has facilitated the diminishment of coverage of nursing home care.

It is our view that expended coverage of nursing home services by Medicare could be achieved if Congress were to insist upon proper implementation of the 1972 amendments to the Medicare statute. By improving the procedural rights of

[1] 16 Gonzaga Law Review, 533 at 544 (1981).

beneficiaries, the entire medical system would better serve older people and nursing home coverage would be improved.

OFFICAL STATEMENT OF THE NATIONAL ASSOCIATION OF MEDICAL DIRECTORS OF RESPIRATORY CARE

The National Association of Medical Directors of Respiratory Care welcomes the opportunity to comment on HR 4227, Congressman Wyden's bill focusing on some of the problems related to Medicare reimbursement in skilled nursing facilities.

The National Association of Medical Directors of Respiratory Care is a professional membership association composed of physicians who have medical responsibility for respiratory care departments in our nation's hospitals. One of our prime concerns is the appropriate and cost effective use of medical gases in our country's health care facilities. Over the past 15 years the practice of respiratory care has changed dramatically as new technologies and scientific data have become available. Unfortunately, the Medicare statutes have not kept pace with these changes.

NAMDRC fully supports the bill HR 4227 as written but would like to take the opportunity to make some comments about current Medicare reimbursement policies in skilled nursing facilities (SNFs). Oxygen is classified as a prescription drug by every state, hospital, and physician in this country, while the Medicare statutes classify oxygen as an item of durable medical equipment (DME). This paradox leads to a recurring problem in our skilled nursing facilities. For example, a patient admitted to a hospital with a diagnosis of severe emphysema and chronic respiratory failure is stabilized and transferred to a SNF. Admitted as a Level One patient, oxygen is covered until improvement in the patient's general condition leads to reclassification as a Level Two patient. At this time the need for oxygen continues but the benefit of durable medical equipment is lost.

It is clear from our correspondence with the Health Care Financing Administration that this matter is not one of regulations, but rather one of legislation. In fact, a letter dated July 6, 1981 from HCFA's Director of Coverage Policy states, "While I share your concern for those patients for whom the program may not make payments for their oxygen needs, the wording in the statute is quite clear. A legislative change would be needed to accomplish the objective you seek."

There are two possible solutions to this situation. The first, and probably the most logical, would be to cease Medicare's policy of classifying oxygen as durable medical equipment. Quite clearly, this is a drug which must be administered only under a physician's order and carefully watched by members of the health care team. Thus, the need for oxygen therapy is determined as the need for any drug is determined. Surely the diabetic patient is in need of insulin independent of the need for a wheelchair or crutches. SNFs should be reimbursed for oxygen by the same criteria applied to hospitals.

The second alternative would be to revise the Medicare statutes to simply reimburse oxygen when provided in a skilled nursing facility. While this does solve the immediate problem addressed, it does not solve many similar problems which arise in terms of the broad definitions of durable medical equipment (and oxygen's inclusion in that definition.)

To assist the Committee in clarifying this matter, I have taken the liberty to include the pertinent correspondence between one of our physician members in Massachusetts and the Medicare carrier and additional correspondence with the Health Care Financing Administration.

NAMDRC hopes the Committee takes this change in the Medicare statutes under careful consideration as it deliberates HR 4227.

WORCESTER HANEMANN HOSPITAL,
UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL,
Worcester, Mass., June 16, 1977.

BLUE SHIELD,
Worcester, Mass.

DEAR MS. HAGGAR: I am writing to you to request an informal review by Medicare on the case of a patient of mine, Miss Constance L. Jasper. Miss Jasper is in residence at the Holden Nursing Home. She was discharged from Hahnemann Hospital to the nursing home with the diagnosis of emphysema, severe with chronic respiratory failure. She was a level one case until she had progressed to the point of being able to walk 50 feet whereupon she had to catch her breath for the next two hours. She is now a level two case. My complaint is that she has had continual refusals by

Medicare to pay for her oxygen. I have failed to understand why this is not a covered item. I have gotten just as much a run-around in a nice bureaucratic way as her friend who handles her finances has.

I am a board certified Pulmonary Disease Specialist and I have prescribed a life saving drug for her. Is a Medicare clerk practicing medicine without a license or are the jungle of rules and regulations such that no one can give me a straight answer. I will restate the problem: a patient of mine, Constance Jasper who has her permanent residence at the Holden Nursing Home has been refused payment for what has been explained to me as a covered expense. The Nursing home does not have oxygen facilities of their own but contracts with an outside company to bring in cylinders for Miss Jasper. For your information her latest arterial blood gases were on 12/30/76, pH 7.32, pO_2 53 and pCO_2 80 on two liters of nasal oxygen.

I hope that this gives you some information on which to act. I would be happy to speak with anyone about this case at any time. I would hope that you would act promptly on this and I expect an explanation of your decision.

Sincerely,

MICHAEL BARON, M.D.,
Assistant Professor of Medicine.

BLUE SHIELD OF MASSACHUSETTS,
Boston, Mass., July 5, 1977.

Miss GLADYS LLEWELLYN,
Worcester, Mass.

DEAR MISS LLEWELLYN: In regard to Miss Constance Jasper's Medicare bill for oxygen, I'm afraid I do not have very good news for you.

As I told you the other day, Medicare B does not provide benefits for oxygen in a Skilled Nursing Facility. I then checked with Medicare A to see if there were any benefits available. The charge for oxygen is incorporated in the Skilled Nursing Facility's per diem rate during the first 100 days, provided the patient is a Level I care.

Unfortunately, since Miss Jasper is a Level II patient, there are no Medicare A benefits. The oxygen is therefore a patient liability.

I realize that the Medicare guidelines do seem unfair, and I do wish there was something I could do to help. However, since these are the rules given us by the Social Security Administration we are unable to change them.

I am truly sorry that I could not be of greater assistance.

Sincerely,

MARY HAGGAR,
Special Services Assistant.

BLUE CROSS/BLUE SHIELD OF MASSACHUSETTS,
Boston, Mass., September 15, 1977.

CONSTANCE L. JASPER,
Worcester, Mass.

DEAR MS. JASPER: As you requested, we have reviewed your claim to decide if the original benefit determination was correct. In reviewing claims such as yours, certain procedures have been established to ensure fairness. These procedures include a new and independent examination of all evidence relating to the claim by a specially trained group of individuals who had no involvement with the initial benefit determination.

The issue in this case is whether or not the prescribed durable medical equipment can be covered.

One of the criteria which must be satisfied before durable medical equipment can be covered is that the equipment be used in the patient's home. Federal guidelines contained in Section 2100.3 of the Medicare Carriers Manual address this particular issue. An institution may not be considered a patient's home if it meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation of injured, disabled or sick persons. Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described above, he is not entitled to have payment made for rental or purchase of durable medical equipment since such an institution may not be considered his home.

As this equipment is not to be primarily used in the home, as defined above, we are still unable to provide benefits on this claim.

If you are still dissatisfied with this review determination, you may request, within six months of this notice, a hearing before a hearing officer if the amount in controversy, the amount of benefits in question is $100 or more. To meet the $100 limitation, you may combine other claims of yours that have been through the review or reopening process within six months of the date of the hearing request. This request must be sent either to this office or to any Social Security office. Either office will be glad to assist you in requesting a hearing.

Sincerely,

IRENE RANDALL,
Med B Informal Review Section.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
HEALTH CARE FINANCING ADMINISTRATION,
Baltimore, Md., March 31, 1978.

Re: Miss Constance Jasper

Hon. JOSEPH D. EARLY,
House of Representatives,
Washington, D.C.

DEAR MR. EARLY: This is in further response to your inquiry on behalf of Miss Jasper's physician, Michael Baron, M.D., Assistant Professor of Medicine, University of Massachusetts Medical Center, Worcester, Massachusetts 01605. Dr. Baron has corresponded with you concerning Medicare payment for the oxygen Miss Jasper required.

I can understand Dr. Baron's concern about the denial of payment for oxygen services he prescribed for Miss Jasper. I regret, however, that there is no provision in the law that would permit payment for the oxygen used by Miss Jasper as a patient in the Holden Nursing Home.

Section 1861(a)(6) of the Social Security Act provides for the coverage of "durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section, whether furnished on a rental basis or purchased" (underscoring added). A brief explanation for this provision may be helpful:

The durable medical equipment benefit is intended for the Medicare patient being cared for at home or living in a residential institution. Patients in a skilled nursing facility which meets the definition of such facility in section 1861(j)(1) (and the Holden Nursing Home does) are usually furnished such equipment and supplies necessary for their use as an ordinary part of the services provided in the institution. To make this home-type benefit available to inpatients of skilled nursing facilities, so that it would be reimbursable to the patient (or his assignee) on a part B reasonable charge basis, would permit these institutions to utilize this coverage to relieve them of the expenses of furnishing equipment ordinarily included as part of the patient's stay—without an equivalent decrease in their daily charge. Residential institutions, on the other hand, do not have available and do not customarily furnish items of durable medical equipment to their residents.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Medicare Bureau.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Baltimore, Md., July 6, 1981.

Mr. PHILLIP PORTE,
President, Phillip Porte & Associates,
Arlington, Va.

DEAR MR. PORTE: This is in response to your June 9, 1981 letter with enclosures to Bob Wren of my staff concerning Medicare coverage of oxygen therapy in skilled nursing facilities (SNFs). You mention this question came up as a specific issue at the spring meeting of the National Association of Medical Directors of Respiratory Care.

The problem of which you write is one that we have addressed many times over the years and is rather clearly delineated in the historical data you submitted with your letter. Regrettably, there is little I can add to the information furnished by Mr. Tierney in his March 31, 1978 letter to Representative Early, a copy of which you enclosed with your letter.

You have cited section 1861(h)(5) of the statute. This section enumerates those services which can be covered by Medicare under Part A, the post-hospital extended care benefit. When a person is no longer receiving covered care in the SNF, either due to benefits being exhausted, or because an SNF level of care is no longer required. Part A benefits for such services are discontinued. The facts would seem to indicate that Miss Jasper's case was one where she no longer required an SNF level of care. Although Miss Jasper continued to reside in the SNF, Medicare coverage of her oxygen therapy was not possible under the durable medical equipment benefit because section 1861(s)(6) of the Act specifically excludes the coverage of this service under Part B of the program when furnished in an institution that provides skilled nursing care and related services for patients who require medical or nursing care.

While I share your concern for those patients for whom the program may not make payment for their oxygen needs, the wording of the statute is clear. A legislative change would be needed to accomplish the objective you seek.

Sincerely yours,

MORRIS B. LEVY,
Director, Office of Coverage Policy,
Bureau of Program Policy.

NATIONAL COUNCIL OF SENIOR CITIZENS,
Washington, D.C., February 12, 1982.

Hon. ANDREW JACOBS, JR.,
Chairman, Subcommittee on Health, U.S. House of Representatives, Ways and Means Committee, Longworth House Office Building, Washington, D.C.

DEAR REPRESENTATIVE JACOBS: The National Council of Senior Citizens, representing over four million low- and middle-income elderly persons throughout the country through over 4,000 clubs and councils, is concerned about improving Medicare coverage of skilled nursing facilities. We request that the following comments be included in the record of hearings which you held on February 2, 1982.

3-DAY PRIOR HOSPITALIZATION REQUIREMENT FOR SNF COVERAGE

The National Council of Senior Citizens believes that the requirement that Medicare beneficiaries be hospitalized for at least three days in order to be eligible for Medicare coverage in a skilled nursing facility (SNF) should be eliminated. We believe that maintaining such a requirement encourages unnecessary hospitalization, helps to increase medical expenditures, and endangers the patient's health.

Toward a public policy which provides for a more humane, more medically appropriate, and economically efficient approach to SNF coverage, the National Council of Senior Citizens supports H.R. 4227 proposed by Rep. Ron Wyden. This bill would eliminate the hospitalization requirement which has outgrown its original intentions, and which has become instead a barrier to SNF care.

We urge that the Committee review the results of the HCFA funded demonstration projects in Massachusetts and Oregon. These projects show that eliminating the prior hospitalization requirement would not raise Medicare program costs and could save money by reducing both the unnecessary hospitalization and the potential for complications leading to stays much longer than three days.

The elderly are facing increased health care expenditures, due to medical inflation which far exceeds the CPI and due to the ill-targeted budget cuts of the present Administration. This is the time for Congress to support legislation such as H.R. 4227. It would render the elderly better off, and it would save money.

The National Council of Senior Citizens urges that, in addition to supporting this proposal, the Congress further explore innovative means such as prospective reimbursement to encourage SNF participation in Medicare.

Thank you for the opportunity to provide comment.

Sincerely,

WILLIAM R. HUTTON,
Executive Director.

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